STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NV
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Nevada's Assurances and Certifications are signed and filed in the office of the Chief of the Bureau of Family Health Services, Judith Wright. Ms. Wright serves as the MCH Chief for Nevada. This office is located at 3427 Goni Road, Suite 108, Carson City, NV 89706. Ms. Wright can be reached at jwright@nvhd.state.nv.us.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Oportunity for public input on the 2006 MCH Block Grant application, 2004 Annual Report, and 2005 MCH Needs Assessment after required public notices was provided on June 24, 2005, at two sites. One hearing was held in Carson City, at the Health Division, and the other teleconferenced to Las Vegas at the same time. The Public Hearing was held on the same day and place as a meeting of the MCH Advisory Board. Written comments were solicited due July 10, 2005. Notice of preparation of the grant, the date and places of the public hearings, and an invitation for comment was published in newspapers on June 3, 2005 in Reno, Las Vegas and Elko and were sent to individuals on the Maternal and Child Health Advisory Board mailing list. Copies of the proposed grant were available by contacting the Bureau and the NEIS in Reno, Las Vegas and Elko. Copies were sent to members of the MCHAB and those who requested them. This application represents priorities established by the Year 2005 Needs Assessment including extensive public comment through the Needs Assessment process and the meetings of the MCHAB. One comment regarding FAS was received at the public hearing. No written comments were received. A copy of the MCHAB's Biennium report which was sent to the Legislature and other interested parties is attached.

A public hearing for the CSHCN Needs Assessment was held before the CSHCN Advisory Committee on January 19, 2005. Comments were incorporated into the document.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

There are many factors that impact the health delivery system in Nevada. The State Health Division seeks to improve the health and well being of all Nevadans through a myriad of programs and activities. In addition its priorities include building the public health infrastructure in the state, eliminating waiting lists for Early Intervention, and addressing bioterrorism. Within this context the Maternal and Child Health (MCH) program focuses on the well being of the MCH populations of women and infants, children and adolescents, and Children with Special Health Care Needs (CSHCN), and their families, addressing in particular those priorities identified in the MCH 2005 Needs Assessment. In Nevada, the MCH Title V Program is located in the Bureau of Family Health Services (Bureau) in the State Health Division. The Bureau serves as Nevada's MCH Agency.

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services.

Nevada is a semi-arid, largely mountainous state with numerous valleys of primarily north-south orientation. The Sierra Mountains form a natural barrier on the west between Nevada and California. The Great Salt Lake Desert isolates eastern Nevada from the population centers of Utah. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17 % is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies or reservations statewide and six military bases located in five counties. As in prior years, Nevada remains the fastest growing state in the nation. In the nine months after the 2000 census was completed Clark County in the south experienced a growth of 90,000, or 6.5% growth to a total population of approximately 1,500,000. According to Census Bureau estimates released April 8, 2004, for the 17th consecutive year Nevada remained the fastest growing state in the Nation. As predicted, most of the growth was in the south, with Clark County gaining more than 200,000 new residents. It is now number 17 on the list of largest U.S. counties, surpassing New York and Philadelphia. Rural Lyon County, in the north, ranked 15th as the fastest growing county per capita in the Nation, also according to Census Bureau figures. No end to Nevada's growth is in sight; the Nevada State Demographer projects Nevada's population will reach 2,442,116 in 2005. In 2004, the State Demographer has estimated Nevada's population reached 2,410,768. Clark County remains the largest in population, with an estimated 1,715,337 or 71% in 2004.

Nevada's 17 counties comprise an area of 110,540 square miles, making Nevada the seventh largest state in the Nation. Of Nevada's 17 counties, Clark and Washoe are considered urban with approximately 87% of the population; Carson City, Douglas, Elko, Lyon, and Storey counties are rural; and Churchill, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties. It should be noted that Carson City and Elko have been designated a Small Metropolitan Area.

It is in this milieu that the following priorities for 2005 from the MCH Needs Assessment were established. They will guide the Bureau's work in the coming year:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH

populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.

7. Decrease the incidence of domestic violence among women of child-bearing age.

8. Decrease the risk factors associated with obesity for children and women.

9. Decrease unintentional injuries among the MCH populations.

As with every state, Nevada's MCH program is based on action taken by the biennial Legislature, which approves, sometimes with changes, the Governor's budget for allocating and appropriating funds and establishing their use. State agencies also establish performance measures and workload indicators to reflect the outcomes of their efforts in the coming biennium. In the 2003 Legislature there were two special sessions, which resulted in an increase in the tax base in the state which put it in better shape than in years past. For 2005, state agencies were instructed to construct their budgets for FY06 - FY07 at two times the expended general funds in the base year (FY04). The Bureau's budgets (MCH and WIC) followed this directive with the only changes in funding those to match what is expected in the various grants and fees that come to the Bureau. The change from the MCH Prenatal and Baby Your Baby programs discussed in prior Title V grant years to a Maternal and Child Health Campaign (discussed in III B) was recommended by the Governor and approved by the 2005 Legislature. Generally the Bureau's budgets for the upcoming biennium show no changes from the 2004-2005 biennium, with no gains and no loses. These budgets were closed (approved) on April 21, 2005. The Bureau's performance Measures, which are included in the budget, are as much as possible based on the findings of the MCH Needs Assessments. For 2006-2007 they include:

1. Percentage of infants born to women receiving prenatal care in the first trimester to promote healthy birth outcomes.

2. Nevada's teen birth rate (per 1,000) among 15-17 year old females.

3. Percent of newborns screened for metabolic disorders and hemoglobinopathies.

4. Percent of newborns screened for newborn hearing.

5. Number of SEARCH and National Health Services Corps primary care provider placements.

6. Percentage of WIC infants partially breastfed.

In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rurality of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. About 12% of Nevadans live in rural and frontier communities, most of which are remote (up to 250 plus miles) from urban centers. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH supervises the Primary Care Development Center (PCDC), Nevada's Primary Care Organization (PCO). The PCDC is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These designations help with the recruitment of providers to underserved areas.

PCDC also manages the J-1 Visa program, which places foreign physicians in underserved areas. In FY03 the process for selecting J-1 Visa physicians was changed to give priority to those who serve in a Federally Qualified Health Center or Tribal Health Center, and to not approve any physicians who would be working at a non-primary care site. Currently, of Nevada's 17 counties, 10 in their entirety are Primary Care and Dental HPSAs, and 12 in their entirety are Mental HPSAs. With the exception of Carson City, the rest of the counties are partial HPSAs in all three designations. There are 24 HPSA designations and one MUP.

These designations help with the recruitment of providers to underserved communities through several programs that PCDC administers. In addition to the J-1 Visa Waiver program, PCDC administers the Student/Resident Experiences and Rotations in Community Health (SEARCH) training program for health care students, and the National Health Service Corps (NHSC). The J-1 Visa program, known as the Conrad 30 program, places foreign medical graduate physicians in medially underserved areas where it is often very difficult to recruit physicians. In FY 05 there are 76 (plus 7 pending) active J-1 physicians practicing throughout Nevada, 94 health care students that have received training through the SEARCH program, and 18 health care professionals that have been placed through the National Health Service Corps.

The PCDC works closely with the Primary Care Association (PCA), the Great Basin Primary Care Association (GBPCA), to promote the placement of health services personnel in underserved areas. It is working with GBPCA in implementing its Statewide Strategic Plan to develop at least 10 new primary care sites over the next five years. It is also working with GBPCA in several community development initiatives around primary care, the largest being in Las Vegas. PCDC also develops sites and places National Health Service Corp (NHSC) and SEARCH providers in clinical and pre-clinical rotations.

PCDC works closely with a number of key organizations involved in the development of primary care resources throughout the state. Included with GBPCA are Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Healthcare Network, and Clark County Health Access Consortium. In FY 05 the Washoe County Access to Healthcare Network applied for and received for the first time in Nevada a CAP grant to promote access to primary care in Washoe County. This is the first CAP grant for Nevada.

Medicaid and the Child Health Insurance Program in Nevada:
Nevada's Medicaid and Children's Health Insurance Program are managed by the Division of Health Care Financing and Policy. The Nevada Division of Health Care Financing and Policy (DHCFP) contracts with two managed care organizations, which provide health care to Medicaid-eligible individuals in Clark County and urban Washoe County. Statewide enrollment in Title XIX Nevada Medicaid is approximately 166,000 and, as of June 2005, 81,861 of these recipients are enrolled in the managed care plans. Others receive care under Fee-for-Service Medicaid. Participants eligible for full Medicaid benefits pay no co-pays or premiums for covered medically necessary services, regardless of enrollment.

Nevada Check Up (the Title XXI State Children's Health Insurance Program) continues to grow as more eligible families learn about program availability. The program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. Currently, Nevada Check Up serves 28,836 children statewide. Of those, 23,715 are enrolled in the contracted managed care plans in Clark County and urban Washoe County. The remaining 5,121 children reside in rural counties and receive care under the Fee-for-Service program. There is no co-pay for covered medical benefits, although families do pay a monthly premium based on income and household size. The 2005 Legislature has assured there will be no cap on Nevada Check Up.

Other Nevadans who are ineligible for traditional Medicaid but still need assistance obtaining health care may benefit from the recent passage of Assembly Bill 493 by the 2005 Legislature. The

legislation allows the Division of Health Care Financing and Policy to apply to the Federal government for a waiver pursuant to the Health Insurance Flexibility and Accountability demonstration initiative. If authorized, the waiver will pave the way for Nevada to provide coverage for medical services or subsidies to three groups: 1) Pregnant women with household incomes between 133 and 185 percent of the Federal Poverty Level; 2) individuals employed by certain small businesses, whose incomes are below 200 percent of the FPL, and 3) low-income individuals who do not qualify for traditional Medicaid but who experience a health crisis that results in unpaid hospital charges exceeding $25,000. The Bureau works closely with the Division of Health Care Financing and Policy to ensure services needed by the MCH populations are provided.

Temporary Assistance for Needy Families (TANF) in Nevada:
Nevada's TANF Cash Grant program serves 8 population subgroups: Single Parents, 2-Parents, 2-Parents in which One or Both are Incapacitated, Non-Needy Caretakers, Kinship Care program, Non-Qualified Non-Citizens, SSI Households and Family Preservation Program. The last 5 of these categories are "child-only" programs in which only the children of the household are eligible for cash assistance.

In state fiscal year 2004, the average monthly number of Total TANF Cash Grants recipients was 24,956, of which 18,644 were children and 6,312 were adults. For state fiscal year 2005 year-to-date (through March 2005), the monthly average is 22,146, which is an 11.3% decrease from FY04. The caseload has decreased from a post-9/11/01 high of 35,122 recipients in May 2002 and is now almost at pre-9/11/01 levels.

Although the continued improvement in Nevada's economy has contributed to the decrease in the TANF caseload since the impact of September 11, 2001, the largest factor has been the Welfare Division's development of strategies to ensure those applying for TANF cash assistance are committed to participating in self-sufficiency programs designed to train and connect recipients to employment.

As an example, under old business operations individuals approved for TANF were scheduled to attend orientation within thirty (30) days of approval to gain a full understanding of what was expected of them in pursuit of self-sufficiency. As a business process improvement, the orientation process was moved to pre-eligibility, allowing all TANF applicants the opportunity to learn what would be expected of them. Surprisingly, approximately 20% of TANF applicants withdraw their applications for cash.

Another business process change required all approved TANF recipients to report for thirty (30) hours of work assignments in the Welfare Office within seven calendar days after approval. When TANF recipients report to the Welfare Office they are assigned non-critical work activities such as paper shredding, photocopying, telephone answering, etc. More importantly, during the thirty hours Welfare Division staff have adequate opportunity to perform a full skills assessment, develop a comprehensive personal responsibility plan, fully address all Child Support issues, identify undisclosed client barriers and establish a long term self-sufficiency plan.

Some newly approved recipients fail to complete this requirement and allow their case to be placed in sanction status. Once in sanction status clients are given thirty (30) days to secure program compliance or case closure will occur. When a case is placed in sanction status, the recipient is notified and all future TANF checks are placed in office pick-up status. When the TANF recipient comes to the office to pick up the check they meet with their case worker to address the non-compliance issue and develop a corrective action plan.

The aforementioned changes have significantly impacted the number of individuals participating in the TANF cash assistance program in FY04 and FY05 YTD.

The following are details about the individual TANF programs supplied by the Welfare Division:

a. AF - Single Parent Household. This is the typical case; usually a single mom & 2 kids. Payment for a 3 person household = $348.00 per month (p/m). Average family size = 2.83.
b. AI -- Two Parent Household (One or Both Incapacitated). This case will have an adult that is incapable of working due to a serious illness or injury. Payment for a 3 person household = $348.00 p/m. Average family size = 3.40.
c. UP -- Two Parent Household. This case has both adults not working but able to. Payment for a 3 person household = $348.00 p/m. Average family size = 4.34.
d. CON -- Child Only Non-Needy Caretaker Household. This is a case where adult relative(s) of the child(ren) are taking care of him/her/them. Payment for a 3 person household = $535.00 p/m. Average family size = 1.62.
e. COK -- Child Only Kinship Household. This case is similar to CON except that these are normally grandparents aged 62 and over and have court ordered custody of the children. Payments are per child. 0-12 years old receive $534.00 per child. Ages 13 and up receive $616.00 per child. Average family size = 1.65.
f. COA -- Child Only Non-Qualified Non-Citizen Household. This case is typically where the parent(s) are not in the country legally but have children that were born here. Payment for a 3 person household = $348.00 p/m . Average family size = 2.46.
g. COS -- Child Only SSI Household. This case has a parent(s) that is eligible for SSI payments. Payment for a 3 person household = $348.00 p/m . Average family size = 2.05.
h. COF -- Child Only Family Preservation Plan Household. This is a case where a severely handicapped child is kept at home instead of being institutionalized. Payments are per child. Any age = $350.00 per child. Average family size = 1.00. This program is scheduled to be transferred to the Mental Health Division effective 01 July 2005 (SFY06 start).

Prior to July 2004 the Kinship program only paid an additional $100.00 per additional child. This was changed starting with July 2004 for a larger payment as stated above.

Average family sizes quoted above are FY2005 year to date.

B. AGENCY CAPACITY

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CSHCN. It does this through partnering and collaborating with a myriad of agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:
* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".
* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".
* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.
* NRS 442.140. Authorizes a state plan for MCH.
* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."

* NRS 442.190. Authorizes a state plan for children with special health care needs.
* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.
* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry
* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN program regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry.

Note: The 2005 Legislature changed the name of the Department of Human Resources to the Department of Health and Human Services. This change will occur in the coming year. For the purposes of this document, DHR will be used when referring to the Department.

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects Registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, Primary Care Organization, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added.

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD), Washoe County District Health Department (WCDHD) and Carson City Health Department to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding supports adolescent health clinics in both Clark and Washoe Counties. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties.

The Bureau is home of a small program that is payor of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program), and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, nutrition and primary care and dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The CSHCN data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening program. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. For those children who are SSI eligible the program supports services that are not covered by Medicaid such as specialty foods required by some children with metabolic disorders. Eligibility for the program is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required.

The Bureau used to have a program that paid for prenatal care for eligible women. This was discontinued in May of 2004. The Bureau now promotes obstetrical services for low-income, high-risk women through a program called the Maternal and Child Health (MCH) Campaign. The Bureau currently has a contract with a community-based provider in Las Vegas, which serves primarily

Hispanic and African American clients. In FY 06 it will have a contract with a community based provider in Reno in addition to the one in Las Vegas. Besides prenatal care, each client is screened for social service needs, nutrition needs, domestic violence, substance abuse, and perinatal depression. These community, direct-service providers will screen all clients for social service, referring to various community agencies as needed, in addition to providing obstetrical services. Early entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. As part of the services provided by the community based provider the infant born to the covered mother is followed to age one. A medical home will be established for the infant when this service ends on their first birthday.

Another part of the MCH Campaign is a toll free bilingual (English and Spanish) Information and Referral Line (IRL) that serves as a referral source for pregnancy care statewide. It is also provides information for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers a service offered through the IRL. Campaign pediatric providers are in Clark and Washoe Counties, and in the rural communities of Armagosa, Austin, Beatty, Elko, Eureka, Gerlach, Hawthorne, Pahrump and Carson City. This number is 1-800-429-2669 (the same number used for Baby Your Baby). The IRL has been a primary component for signing up women, infants and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, adoption, substance abuse treatment, a source for dental care, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA and the Bureau's MCH Campaign providers and CSHCN program. A third part of the MCH Campaign is an outreach campaign that includes a mass-media campaign, again in both English and Spanish, that educates the public about pregnancy and other related matters. The Bureau has contracted with the Nevada Broadcaster's Association to air both radio and television announcements about the importance of early and continuous prenatal care, information about Medicaid and Nevada Check Up, proper nutrition during pregnancy, and where care may be obtained. This outreach campaign is funded by a contract with DHCFP, Medicaid. For each dollar that the Bureau spends on public education, Medicaid will match it.

The Bureau also now has a toll-free IRL for CSHCN. This new phone number is currently being marketed through a media campaign. It refers callers to services available in the state for CSHCN and their families. This number is 1-866-254-3964.

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. The CSHCN Program does not serve those eligible for Medicaid or Nevada Check Up (unless it is a service such as specialty foods that Medicaid or Nevada Check Up do not pay for). This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has a web page where a description of Bureau programs and initiatives may be found and links to web pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web page is located at http://health2k.state.nv.us/bfhs/. Program web pages can be accessed through the Bureau's main web page. The Prenatal web page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web pages on the SHD web-page, receiving several hundred hits a week. A new CSHCN web page was launched in January 2005. It contains links to Medicaid, Nevada Check Up, Food Stamps, SSI, and other programs that might be useful for CSHCN and their families. It is currently being marketed through a media campaign.

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. Through contacts between the two agencies and

interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid including the contract for the MCH Campaign. Referrals to Nevada Check Up and Medicaid are made through the CSHCN Program, the MCH campaign and WIC, and in FY 06 through the Real Choice Systems Change pilot projects discussed below.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, Diabetes, and Cleft/Craniofacial clinics in Reno and Las Vegas. The Bureau Chief and a UNSOM Geneticist are currently working out the details of a Fetal Alcohol Syndrome multi-disciplinary clinic that will first be held in Las Vegas. A vision care clinic also in Las Vegas at a Early Intervention site has recently been proposed and is under consideration.

The Bureau is working very closely with the new Office of Disability Services and Community Based Services which are in DHR Director's office. The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. It was also the lead on a "211" line for one-stop referrals proposed during the current legislative session and worked with the Bureau to ensure the Bureau's hot lines were appropriately included. This bill did not make it out of session; it was however reintroduced in an omnibus bill that included $200,000 to implement a 211 line. A committee of representives from the various DHR Divisions including Health's MCH is currently meeting to begin the development of the line.

The Department of Human Resources is the recipient of a three-year Centers for Medicare and Medicaid Services (CMS) $1,385,000 grant to build systems of care for Children with Special Health Care Needs. This is a "Real Choice Systems Change" (RCSC) grant. This DHR grant was placed in the Bureau for implementation. It experienced a delay in implementation which will lead to a fourth year into FFY 06. Its components are a CSHCN Advisory Committee, a CSHCN Needs Assessment, a web page, and 3 pilot projects implementing the findings of the Needs Assessment for CSHCN systems development. The media campaign is currently underway (and is the one marketing the CSHCN web site and IRL.) The Needs Assessment was completed in January 2005 and the Advisory Committee appointed; several meetings have been held. The Advisory Committee has had a subsequent meeting to review the findings of the Needs Assessment and is overseeing the pilot projects that the grant calls for based on the findings of the Needs Assessment. The CSHCN Needs Assessment is a complete in-depth assessment of CSHCN in Nevada to provide a better understanding of the nature and magnitude of challenges facing CSHCN ages birth to 22 and their families in Nevada (e.g., the level of need, amount of services available, amount of services required, service gaps, cultural issues, service duplications, etc.). The data generated by this study will help address CSHCN systems development. Three pilot projects, northern urban, southern urban, and rural, are in the process of being developed and implemented based on the findings of the Needs Assessment. The data generated from the needs assessment will also be used to develop public policy initiatives and demonstration projects to ensure coordinated, family-focused, and community-integrated systems of care for all of Nevada's Children with Special Health Care Needs. This includes family partnership in system planning and service selection, effective supports for CSHCN transitioning to adult life, and better-coordinated care throughout childhood and into young adulthood. This is the piece that is being coordinated with the Office of Disability Services.

The PCDC partners very closely with the Great Basin Primary Care Association and its members to promote access to primary care for all Nevadans including pregnant women, infants, children and adolescents, and CSHCN. In many rural parts of the state as well as in Washoe and Clark Counties GBPCA members are the only providers available for primary care including infant well-child and other care partricularly for low income individuals. In 2005 one of its members, Nevada Health Centers, also became a WIC provider in Southern Nevada. In addition, the MCH supported Community Health Nurses of the BCH provide well-child services for infants in the rural counties.

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas. The Child and Adolescent Health Coordinator will work with the Adolescent Clinics in the coming year to assure they continue to address identified needs. For FY06 the contract in Washoe County was out to bid in FY 05 and will stay with WCDHD. The Huntridge Teen Clinic in Las Vegas was bid this year (2005) and stayed with the same contractor.

The MCH Chief serves on DHR's Child Care Advisory Committee, representing the SHD to promote health concerns. The Child Care Steering Committee includes representatives of Health, Welfare, Dept. of Education, Nevada's Community Colleges, University of Nevada, Head Start, Welfare contractors, Consumers, Family to Family Connection, etc. It is charged with advising the Department of Human Resources and the Governor on improving quality and availability of child care for Nevada's children, particularly those services provided to TANF recipients and clients who are receiving transition services from TANF. The MCH Chief is one of 4 state employees on this Committee.

The MCH Chief participates in the Title V-B Steering committee for Family Preservation and Support. The MCH Chief will continue work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program. Through the DHR Child Care Advisory Committee, the MCH Chief continues to promote the inclusion of training for care of CSHCN in all training initiatives. The inclusion of CSHCN in all publicly funded child care including those sites receiving assistance with development and training from Welfare is also promoted.

The Bureau continues to work with the Welfare Division for the training of Child Health Care Consultants. The federal grant supporting this initiative which was held by the University of Nevada Reno has ended. In 2006 the initiative will be continued in rural counties by the Community Health Nurses of the BCH, and in Washoe County with support from child care dollars from Welfare. The Bureau has become the lead agency for this initiative in the process.

Nevada Revised Statutes state that all child care providers must attend a class that covers preventing and recognizing illnesses. In the past, this class has been held only in Clark and Washoe Counties on a regular basis, and Bureau personnel have given the class when possible in the rural counties and parts of Clark County. Most child care providers have not been able to receive this class due to access issues. However, now all community health nurses in the rural counties have been trained by Bureau personnel to teach the "Prevention and Recognition of Illnesses in the Child Care Setting" class. In addition, Southern Nevada Area Health Education Center (AHEC) personnel located in Clark County are being taught the curriculum so that they can service the outlying areas of Clark County. In the near future, this class will be available state-wide and all child care providers should be able to access this class easily.

The 2005 Legislature approved the establishment of an Office of Minority Health effective July 1, 2005, in the DHR Director's office. This has been a goal of the Department for many years. The purposes of the Office are to improve the quality health care services for members of minority groups; increase access to health care services for members of minority groups; and disseminate information to and educate the public on matters concerning health care issues of interest to minority groups. The Bureau will partner with the new office to address minority health and health disparities in all its efforts.

The Bureau works with all known parent and advocacy groups such as Parents Encouraging Parents (PEP), Family Voices, "Nevada Partners in Policymaking" and the "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check Up, Vocational Rehabilitation, Shriner's, and the Department of Education, for access to, and coordination of, services. The meetings included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents, of children who have a variety of disabilities and needs. This also provided an opportunity to dialogue

with members of the community and the staff of multiple community agencies. As a result, there is increased communication within a growing network of service organizations and consumers. Family Voices was very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and will assist with implementing its findings. The CSHCN program now includes information about Family Voices in all its communications with families. All of these agencies and consumers are involved in the development of the Real Systems Change initiative. The Family Voices Director is developing the RCSC media campaign.

C. ORGANIZATIONAL STRUCTURE

Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor is Kenny Guinn, now in his second four-year term, which expires in January 2007. Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch includes the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons. An org chart of Nevada State Government may be found at http://www.leg.state.nv.us/lcb/research/StateOrgChart.pdf.

The state public health agency, the State Health Division (SHD), is in the Department of Human Resources (DHR). DHR also includes the state mental health agency, the Division of Mental Health/Developmental Services(MH/DS); the social services/child welfare agency, the Division of Child and Family Services; Aging; the Medicaid and Nevada Check Up agency, the Division of Health Care Financing and Policy(DHCFP); and the TANF and Child Care Block Grant agency, Welfare. Mike Willden is the Director of DHR. The org chart for DHR may be found at http://hr.state.nv.us/Documents/DHR_904.pdf. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives.

As noted in III.B, Agency Capacity, Nevada Revised Statute 442 designates the Department of Human Resources through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CSHCN programs are in the Bureau of Family Health Services.

The SHD contains 7 Bureaus all headed by a Bureau Chief. In addition to the Bureau of Family Health Services they include Community Health (BCH), Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), Early Intervention Services (BEIS), Health Protection Services (BHS), and Alcohol and Drug Abuse (BADA). Alex Haartz, MPH, is the Administrator of the SHD. Mr. Haartz received his MPH from Tulane University. Prior to coming to the SHD he was with the San Diego County Department of Health providing public health education. He began his career with the SHD with the Bureau, and is an advocate for MCH. The State Health Officer is Dr. Bradford Lee. Dr. Lee came to the SHD from the United States Air Force, where he served for more than 29 years. His medical degree is from Howard University, College of Medicine; his Juris Doctorate is from the University of the Pacific McGeorge School of Law. The SDH organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all six of the other Bureaus. It provides funding for Community Health Nurses in BCH and partners with BCH on chronic disease initiatives. The Center for Health Data and Research in the BHP&VS works with the SSDI grant and produces the data for the MCH Block Grant application and oversees the MCH Needs Assessment process. BADA works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. A bill in the 2005 Legislature will move BADA to MH/DS; even should this move occur the Bureau and BADA will continue to collaborate. While the Bureau's Oral Health Unit has the fluoride initiative, BHP

has the engineers that monitor the water systems. The Bureau works with BLC on emergency medical services and on Newborn Intensive Care Unit regulations, which they regulate. Finally, the BEIS is collocated with the Bureau and works closely with the CSHCN program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau also supports the multi-disciplinary specialty clinics held in BEIS facilities. The Bureau org chart is attached.

The Bureau of Family Health Services under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all go to promote the health and well being of Nevada's families. Judith Wright is the Bureau Chief and MCH Director.

Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the Governor from a list provided by the SHD Administrator to two year terms, and two legislators appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS the MCHAB is advisory to the Administrator of the SHD. They meet 4 to 6 times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and have testified before the Legislature on bills of concern to the Department. They produce a bi-annual report includes a report of their activities for the biennium and recommendations for the coming biennium. This report is placed on the Bureau's web page and some hard copies distributed at the Legislature. The 2005 report is attached to I.E, Public Input, as is noted there. The MCHAB is staffed by the MCH Bureau Chief. Under NRS they are charged to advise the Administration of the SHD "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:

1. Ensuring the availability and accessibility of primary care health services;

2. Reducing the rate of infant mortality;

3. Reducing the incidence of preventable diseases and handicapping conditions among children;

4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;

5. Preventing the consumption of alcohol by women during pregnancy;

6. Reducing the need for inpatient and long-term care services;

7. Increasing the number of children who are appropriately immunized against disease;

8. Increasing the number of children from low-income families who are receiving assessments of their health;

9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and

10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);

11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and

12. Promoting the health of infants and mothers by ensuring the availability and accessibility of

affordable perinatal services."

The Bureau is also advised, as are other agencies in state government, by the Governor's Youth Advisory Council (GYAC). The GYAC was originally established by Governor Robert Miller in 1995 by executive order and has been continued by Governor Guinn. The GYAC is comprised of 11 youth ages 15 - 21 from statewide, of mixed ethnicities and race. They are staffed by the Bureau's Child and Adolescent Health Manager. For 2006, the GYAC has established as its priorities teen pregnancy prevention, violence prevention, and suicide.

The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. As MCH is not regulatory it does not have much activity before the SBOH, but it does go before them to set fees for Newborn Screening and other matters that are contained in the NRS for the Bureau. The Newborn Screening fee increase was approved by the SBOH in September 2003. In 2004 the Bureau partnered with BLC to update the NICU regulations, which were approved by the SBOH on June 25, 2004.

The CSHCN Program has already been described in III.B. Agency Capacity. It pays for treatment for eligible children. The CSHCN program includes Newborn Screening, Newborn Hearing Screening, and the Birth Defects Registry. These three programs are all required by NRS. The Newborn Screening and Birth Defects Registry programs and the program's supervisor are funded by newborn screening fee revenue. Newborn Hearing is funded by HRSA (this grant will end in 2006). CSHCN also includes the Real Choice Systems Change Grant that is funded by CMS.

The MCH Perinatal and Women's Health program includes the Perinatal Substance Abuse Prevention (PSAP)program, the MCH Campaign, and Domestic Violence, Injury and Rape Prevention programs. Injury and Rape Prevention are funded by CDC. PSAP is funded by state general fund. The supervisor of the unit is funded by Title V, the MCH Block Grant.

The MCH Perinatal and Women's Health and CSHCN Programs are headed by Health Program Specialist IIs.

The Child and Adolescent Health Program addresses teen pregnancy prevention and other initiatives to promote the health and well-being of Nevada's children and adolescents. It includes the Abstinence Only grant now managed by the Administration for Children and Families. It also includes the MCHB Early Childhood Systems Development grant, and with the additional funding from the MCH Block Grant the state received has a component for Early Childhood systems development for ages 6-10. It is headed by a Health Program Specialist II who is funded by Title V, the MCH Block Grant.

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), Early Childhood Caries prevention, Oral Health Surveillance, and is developing an oral health curriculum for primary and secondary education. It is funded by CDC and MCH Block Grant. The Oral Health Unit is headed by a Health Program Specialist II who is funded by the CDC grant.

The WIC Program has clinics statewide. It is currently serving approximately 46,000 participants a month. It is funded by USDA and rebates. It is headed by a Health Program Manager II who is funded by the WIC grant. WIC expects to reach 60,000 by the end of the next biennium (FY2006-FY2007.

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, SEARCH from the Bureau of Health Professions and the HRSA/MCHB funded SSDI program. It is headed by a Health Resource Analyst III who is funded by the Primary Care grant.

Specific staff of the Bureau are listed in III D. Other (MCH) Capacity.

Title V funding is also placed as previously mentioned in the Community Health Nursing budget and in Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Bureau Chief assures the funding is being spent in accordance with federal regulation.

D. OTHER MCH CAPACITY

Nevada's MCH/CSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. Staff who are located in the Carson City and Las Vegas offices are listed in the attached table along with CVs of program managers.

Judith Wright, Bureau Chief, is a graduate of the University of Chicago, Chicago, IL. She has been in Public Health since 1978, and MCH specifically since 1989, having formerly served as a WIC Administrative Officer and then CSHCN Director in Montana. She came to Nevada to become Bureau Chief in September 1994. She directly supervises an Administrative Assistant IV, an Accounting Assistant III, and the Bureau's Administrative Services Officer I. She also supervises the managers of CSHCN, the CSHCN Registered Dietitian, Women's Health/Perinatal, PCDC, WIC, Oral Health, Child and Adolescent, and Real Choice Systems Change. There is also a bilingual Administrative Assistant I assigned to the Bureau overall. The Administrative Assistant IV supervises all the clerical staff in the Bureau with the exception of those in PCDC.

Gloria Deyhle, RN, Health Program Manager II, CSHCN Manager, got her nursing degree from Mount Sinai Hospital School of Nursing. She has been CSHCN Manager since 1990, having previously worked as a Medicaid Services Specialist in the Welfare Division. The CSHCN Program staff also includes a contractor for newborn hearing (the grant ends in 2006), a Health Program Specialist I for the Birth Defects Registry, and two Family Service Specialist IIs and an Administrative Assistant III for the payment portion of the program. There is one Administrative Assistant I assigned to this program.

Cynthia Huth, CNM, Health Program Manager II, Women's Health/Perinatal Coordinator, received her MS in Nursing/Midwifery from the University of Utah. She was a practicing midwife until 1996 when she came to work for the Bureau as a Perinatal Nurse Consultant. This unit includes two Health Program Specialist Is for Perinatal Substance Abuse Prevention and Injury/Rape Prevention. There is one contracted bilingual Administrative Assistant I assigned to this program for the MCH Campaign and a .5 FTE Administrative Assistant I for Injury Prevention.

Mark Hemmings, Health Resource Analyst III, PCDC Manager, received his Masters from Central Michigan University (Extension), Honolulu, Hawaii. Before becoming manager of the PCDC in 2002 he was a Health Resource Analyst in the Bureau of Health Planning and Statistics. PCDC includes a Health Resource Analyst I for SEARCH, a Health Resource Analyst II for NHSC, a Health Resource Analyst II for SSDI, and 1.5 Administrative Assistants Is.

Steve Kepp, Administrative Services Officer I, received his MBA from Nova Southeastern University in Florida. Before coming to the SHD in 1998 he worked for a Construction company in Wyoming.

Kyle Devine, Health Program Specialist II, received his MSW from University of Nevada Reno, and is the Bureau's Child and Adolescent Coordinator. Prior to coming to the State he worked for Lassen Diversified Management of Susanville California in charge of their Tobacco Control initiative. This unit includes three Health Program Specialist Is, for Early Childhood Systems Development birth to five, Childhood Systems Development ages six to ten, and Abstinence-Only. It has an Administrative Assistant I assigned to it.

Christine Forsch, Health Program Specialist II, Oral Health Program Manager, is a graduate of Kennedy Western University, and a Registered Dental Hygienist (RDH). Prior to becoming the Oral Health Program Manager, she served as the State's Oral Health lead as a contractor in the Bureau. In addition the Oral Health Program has a Biostatistician, a Health Educator, two half-time RDH contractor educators, a contracted half-time collaboration specialist and a contracted half-time time evaluator. There is an Administrative Assistant II assigned to it.

Debra Wagler, Health Program Manager I, Real Choice Systems Change, received her MA from California State University. She also has a MA from Nanyang Technological in the Republic of Singapore. The RCSC initiative also has a Management Analyst II, and an Administrative Assistant I assigned to it.

Doug Schrauth, Health Program Manager II, WIC Manager, is a graduate of Cal-State University in Hayward, CA. Before coming to be WIC Manager in 2002 he was SHD Internal Auditor. The State WIC Office has a Health Program Specialist II Registered Dietitian, a Management Analyst II, a Computer Services Technician II, an Accounting Assistant and an Accounting Technician. There is an Administrative Assistant III assigned to it for vendor monitoring and training. WIC now has an office in Las Vegas, which has a Health Program Specialist I breastfeeding Coordinator, and will have a Health Program Specialist I trainer. The Las Vegas office has a contracted Administrative Assistant. It will house the Birth Defects Registry HPS I when that vacancy is filled.

In 2003 the WIC program released a Request for Application for WIC agencies who would take over state run clinics in the rural counties (the urban counties Washoe and Clark were already served by contracted agencies). This RFA was completed and a second one released that has been left open. The goal is to have the state WIC office get out of providing direct services and assume a solely management role. At this time only four rural counties have state-run WIC clinics, Douglas, Humboldt, Churchill and Pershing. The remainder have been turned over to locally community-based organizations that include Family Resource Centers and Head Start. There are also additional contractors in Clark and Washoe Counties. Additionally, WIC is on task to convert WIC benefits to Electronic Benefit Transfer (EBT). It has added contracted staff to work on the conversion. It has also added a contractor to help with vendor monitoring and a contractor to help with financial management of the program, for a total of 4 WIC contractors. WIC is currently undergoing a reengineering study to help it determine its configuration after conversion from state to locally run clinics and the impact of EBT on the caseload. This study is due this summer. WIC currently has 26.79 FTEs, but this will change in the coming year.

E. STATE AGENCY COORDINATION

As indicated in III.C, the agencies of public health (State Health Division), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada Check Up (Division of Health Care Financing and Policy), Aging and TANF and Child Care (Welfare) are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives, described below.

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in III.B and IV.B and IV.C. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Health Planning and Vital Statistics (HP&VS), Health Protection Services (HPS), Community Health (BCH), Licensure and Certification (BLC), and the newest Bureau, the Bureau of Early Intervention Services (BEIS) which joined the SHD in FY04. The main office of BEIS is collocated with the Bureau in Carson City.

The Bureau partners with the Department of Education and with local (county) school districts around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. It works with the Department of Education on an oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy prevention, substance abuse, and injury prevention.

The Bureau is partnering through the MCH Campaign with the Department of Corrections to promote healthy birth outcomes in incarcerated women and good parenting. The Perinatal/Woman's Health Consultant is developing training modules that will be used by Department of Corrections staff, including one on the stages of pregnancy and another on an infant's health. Modules have also been completed on Postpartum issues and Infant Development.

The 2001 Nevada Legislature passed AB513, which appropriated funds for the development of four long-term strategic plans relating to the health care needs of Nevada residents. The project was lead by a Steering Committee to which four Task Forces report, one of which is for Disabilities. The other Task Forces were for Seniors, Rural Health and Rates.

The Disability plan was charged to "ensure the availability and accessibility of a continuum of services that appropriately meet the basic needs of persons with disabilities in Nevada". Based on this study the 2003 Legislature moved Community Based Services from the Department of Employment, Rehabilitation and Training (DETR) to DHR and also created in DHR a new Office of Disability Services and moved DETR's Traumatic Brain Injury program into it. The Bureau is working very closely with the new Office of Disability Services and Community Based Services. In particular the Office of Disability Services is working closely with the Real Choice Systems Change (RCSC)project discussed in III B.

The RCSC project team has developed an interagency working group to bring all providers of services for the CSHCN population together. This CSHCN Advisory Council's membership includes parents of CSHCN, adolescent CSHCN, advocates, providers, and educators. The Advisory Council serves to guide project activities and to provide a forum for issues of interest to Nevada's CSHCN and their families. The Real Choice program manager acts as a liaison between the Advisory Council and the Children's Disability Subcommittee created as part of the Disability Task Force to assure that project activities are in line with the objectives of Nevada's Strategic Plan for People with Disabilities. While coordination with some agencies is easier than with others, there has been interest in developing a cross-departmental system of care for CSHCN and the RCSC project is working to take advantage of this culture of change.

The Real Choice Project Team has also been attending meetings of and working with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. This forum addresses issues inherent to transitioning youth with special health care needs and has formal relationships with DETR and school districts.

The Bureau works closely with the University of Nevada School of Medicine (UNSOM). The Birth Defects Registry initiative currently in process will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. In 2005 the Bureau is working with the geneticist of UNSOM to establish a Fetal Alcohol Syndrome (FAS) multidisciplinary clinic in Las Vegas. Once this clinic is established a plan will be created to have a FAS clinic in the north. The Bureau also works closely with AHEC, whether it is using their expertise to plan and conduct meetings or the partnership with PCDC on rural mental health issues.

The Bureau partners closely with the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD), which both have MCH programs. A third Health District, Carson

City (which is a County), was added late in 2004. There are now three county health departments in Nevada. The remaining 14 counties are served through the SHD. Representatives of the CCHD and WCDHD sit on the Maternal and Child Health Advisory Board and work very closely with the Bureau on MCH issues.

Through the PCDC the Bureau works very closely with the Great Basin Primary Care Association (GBPCA, the state's PCA) and its members to promote access to primary, dental and mental care for underserved Nevadans. These members include Federally Qualified Health Centers, Tribal Clinics, Rural Health Centers, Nevada Health Centers, etc. The executive director of GBPCA is the current chairman of the Maternal and Child Health Advisory Board. Nevada Health Centers has just become a WIC provider in southern Nevada.

The WIC Program is in the Bureau and partners with many of the other programs in the Bureau such as Oral Health and Women's Health/Perinatal. In the past year WIC has been turning its state-run clinics over to local community-based organizations who are now partners with WIC. It has also gained additional WIC agencies in Clark and Washoe Counties. As this is written there are state-run clinics in just Douglas,Churchill, Humboldt, and Pershing counties; the rest are run by CBOs that include Family Resource Centers, a Head Start, Nevada Health Centers, and a hospital. A proposal by Pershing County to take over WIC was received in June 2005.

The Teen Pregnancy Prevention initiative works with the various Family Planning organizations in the State, including those services of the Community Health Nurses of BCH and the private organizations in Reno and Las Vegas. In 2004 Nevada was one of several states selected to work together on developing a common Action Plan around Teen Pregnancy, STD, and HIV/AIDS prevention. This initiative is continuing and will continue into FY 06. The Stakeholders Group, as it is called, is now looking at approaching the issues of teen pregnancy, HIV and STD prevention from an adolescent risk reduction perspective. This will be discussed more under National Performance Measure 08.

The Oral Health initiative also has many partnerships. The State Dental Health Consultant (to the CDC grant) is from the University of Nevada Dental School. The initiative has both a state advisory committee and local coalitions in Reno, Washoe, and Lyon counties, with more in process. Members of the various coalitions and the state advisory committee include representatives of the State Dental Association, State Dental Hygienists Association, the State Board of Dental Examiners, UNSOM, the Dental School, consumers, the GBPCA, Washoe County District Health Department, Clark County Health District, Tribal Health, local Churches, a hospital and the State Aging Division. Meetings are usually attended by representatives of other public agencies that include Medicaid and the Nevada Public Health Foundation.

Through the partnership the Bureau has with Medicaid and Nevada Check Up, Bureau programs are referral sources for both programs. Bureau staff are able to access the Medicaid data system to confirm Medicaid eligibility or ineligibility when considering eligibility for the CSHCN Program. The Bureau has a contract with Nevada's Division of Health Care Financing and Policy (Medicaid) to provide public education through the Maternal and Child Health Campaign about the importance of early and continuous prenatal care, other pregnancy related issues and infant care. Pregnant women and infants and children are also informed about the Medicaid (including EPSDT) and Nevada Check Up programs and referred to the programs if indicated. In addition, the Real Choice Systems Change project has worked with Medicaid and Nevada Check up staff on an outreach campaign to sign children up for Medicaid and Nevada Check Up, and perform outreach for CSHCN services at the same time. The Bureau's pilot projects for RCSC will work with DHCFP to increase EPSDT usage by Medicaid children, a goal of the grant.

The CSHCN program also uses SSI for a referral. Program regulations require a denial from Medicaid, SSI, and Nevada Check Up for those children whose family income and for SSI the child's condition appear to meet those eligibility criteria.

Through the various programs in the Bureau the Bureau has contact with all the birthing facilities in

the State. It works with them on issues such as newborn screening, newborn hearing screening, the Birth Defects Registry, and the MCH Campaign. In 2004 it worked with representatives of all the NICUs in the state to revise the NICU regulations that are in NAC.

Along with moving all Early Intervention Services to the SHD, the Director also moved the Head Start State Collaboration to the Welfare Division with the Child Care Unit. The 2005 session is now moving it to the DHR Director's office. The Bureau has representation on both the Head Start State Collaboration (the Bureau Chief and Oral Health) and the DHR Child Care Advisory Committee (the Bureau Chief) and ensures that health needs including those of CSHCN are part of every discussion of services. Both the Head Start State Collaboration and DHR Child Care Advisory Committee have similar memberships and frequently have similar agendas items. In June of 2005 it became clear that the Head Start mandate to a strategic plan and the Early Childhood Comprehensive Systems (ECCS) strategic plan are addressing the same populations. The two initiatives are being combined to produce one plan for ECCS that includes Head Start.

As noted in III.B, the Child Care Health Consultant (CCHC) program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. The Bureau's Early Childhood Comprehensive Systems program is working to continue this program. The CCHC leadership is being transferred from the University of Nevada, Reno, to the Bureau where it is being integrated into the ECCS program. The Bureau is awaiting word on where the training for CCHC trainers (train the trainers) will be in the future. Plans are to send two or three community health nurses from BCH for training as trainers. They will then train all the CHCs as CCHC. This will take care of rural communities. The Welfare Division, Child Care Unit, has agreed to cover the salaries of two nurses who are already trained in Washoe County. This will leave Clark Countywith a need for CCHC trainers, which will not be addressed until next year.

F. HEALTH SYSTEMS CAPACITY INDICATORS

The Center for Health Data and Research (CHDR) has the primary responsibility for obtaining the data for this application, including that for the Health Systems Capacity Indicators (HSCI). They worked with Bureau staff to obtain the data that is not contained in the CHDR's data warehouse. The warehouse includes birth and death certificates, hospital discharge data, WIC, Medicaid encounters, census and demographic data, Trauma Registry, etc. and is able to produce most of the HSCI data through data linkages. There are currently almost 30 databases in the CHDR data warehouse.

HSCI # 1 has seen a small increase in the rate of children hospitalized for asthma. Nevada is a desert state with a lot of pollen, and a lot of dust stirred up during the ongoing building in Clark County; asthma is a major health problem in the state.

HSCI # 2 has seen a small increase. Access to EPSDT and the EPSDT rate are a concern of DHCFP. In FY04 Medicaid partnered with the Bureau' MCH Campaign, which was a referral source for Medicaid (and Nevada Check Up) and referral to pediatricians and Family Practice doctors who would see children covered by Medicaid as well as have a sliding fee scale. Access to care is an issue for this indicator.

HSCI # 3 has seen a decrease. This could perhaps be attributed to work on DHCFP's development of a new MMIS system, and problems with getting reports out of the old one. It is a challenge every year to obtain the data for this measure as well as HSCI # 2. The Real Choice Systems Change project is partnering with Nevada's Covering Kids project (for Medicaid and Nevada Check Upoutreach) to promote access to care for all children including CSHCN.

HSCI # 4, After a decrease in FY03, FY 04 saw a small increase in this measure regarding number of prenatal visits. As noted in III.B., Agency Capacity, the State Health Division through the Bureau

instituted the Maternal and Child Health Campaign. This prenatal campaign targets high risk populations to encourge early and continuous prenatal care. It also serves as a referral source for Medicaid and Nevada Check Up. It also provides funding to support the provision of prenatal care for underserved women that will include ancillary services such as transportation, referral to substance abuse treatment, screening and provision of assistance for domestic violence, etc. As part of the MCH Campaign in FY 06 a community based organization in Las Vegas and one in Reno will provide care for women with no coverage for prenatal care.

The data in HSCI # 7 as with HSCI # 2 indicates the continued need to perform outreach for Medicaid. The Bureau's Oral Health Program is partnering with Medicaid to recruit dentists who will serve the underserved, including Medicaid clients, which are mainly children as Nevada Medicaid covers only emergencies for adults. The Primary Care Development Center continues to recommend Dental HPSAs, which makes communities eligible for dentists who can get licenses to serve in them without taking the state's dental exam. It partners with the Great Basin Primary Care Association whose web site contains a recruitment for dentists to underserved areas (http://www.gbpca.org/dental/licensure.htm).

HSCI # 8. The percent of SSI beneficiaries receiving services from CSHCN remains static year to year depending on how many children are served by Early Intervention and other factors. The only children served by both SSI and CSHCN are those seen in Early Intervention and in the specialty clinics. This number comes from the estimated number of children served by Early Intervention who are on SSI (numerator) and the number of children total on SSI for CY 04 (denominator).

Form 18. This data comes from the CHDR. As has been noted in this section and in the report on Performance Measures, the Bureau continues to partner with Medicaid on outreach and getting women early and continuously to prenatal care, and infants born at Level III hospitals if they are at-risk.

Form 19. The Bureau is the applicant in a grant application to MCHB for HRSA CFDA #93.110W regarding "State Systems Development Initiative", which ends in FFY 05. The intent of the application is to improve Nevada MCH's data capacity by linking databases to track health status indicators and continue to add databases to the SHD interactive web-based database initiated through the Maternal and Child Health Internet-Query Module (MatCHIIM) and INPHO the prior years. This project supports the activities of the CHDR.

The SSDI grants have addressed and continue to support the data linkages in the CHDR.
SSDI supported the linking of the following databases:
a. Infant birth
b. Infant death
c. WIC eligibility
d. Newborn screening
e. Birth defects registry
f. Medicaid and Nevada Check Up (S-CHIP) eligibility
claims
g. Hospital discharge
h. mental health database
i. Youth Risk Behavior Survey

The CHDR is headed by Wei Yang, MD, Ph.D., Biostatistician.

A noted before, Nevada's Birth Defects Registry (BDR) is currently a "passive" registry, collecting information off of birth certificates. Funding from CDC enabled the collection of a full year (2001) of statewide "active" birth defects collection, giving the state a base year. A database was established for the BDR, which is housed in CHDR along with the Newborn Screening database. The 2003 Legislature directed the increase of the state's newborn screening fee to enable the establishment

again of an "active" BDR. This regulation change was approved by the State Board of Health in September 2003; revenue had to accrue through FY04 before an FTE could be hired effective July 1, 2004. The Bureau is currently recruiting for an FTE who will be charged with re-implementing an "active" collection BDR. This FTE will be based in Las Vegas. This system will become part of the CHDR data warehouse.

In the past the SHD has done a PRAMs-like survey of recent mothers through the BYB program. This ability is no longer available due to confidentiality laws, which limit the use of birth certificate data in NRS. The Bureau is investigating other ways to get this information.

The State Department of Education conducts the Youth Risk Behavior Survey along with the Safe and Drug Free School Survey. It is given to middle and high school students, with some of the questions not appropriate for middle-schoolers left off the questionnaires distributed to them. Nevada is one of the few states that has weighted data so that each school district can have data that is weighted for its local use. The State Department of Education has given the 2005 YRBS database to the CHDR and it is available on their website.

The CHDR does not have electronic access to the Pediatric Nutrition Surveillance System (which is collected on WIC clients). This data is sent to CDC for analysis.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Nevada's priorities and initiatives are based on the MCH/CSHCN Five-Year Needs Assessments completed in January and May 2005. "Focus groups" were established to publicly discuss the inadequacies and inequalities among the 3 MCH populations in Nevada (pregnant women and infants, children and adolescents, and CSHCN). The focus groups were a tool to build bridges among traditional and non-traditional partners in the community; they were a primary source of information that helped shape the foundation of the Year 2000 Needs Assessment. In an improvement over the 2000 Needs Assessment, the Bureau was able to utilize the data warehouse in the CHDR for Primary and Secondary data sources. No additional surveys needed to be done. Presentations were also made to the Maternal and Child Health Advisory Board and the Governor's Youth Advisory Council, and a statewide videoconferenced public hearing was held to discuss preliminary findings and shape the final outcomes of the Needs Assessment. The persons involved in the Year 2005 Needs Assessment were very vocal, creative, and mindful of the populations they serve.

The priorities identified by the Year 2005 MCH Needs Assessment include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations

7. Decrease the incidence of domestic violence among women of child-bearing age

8. Decrease the risk factors associated with obesity for children and women

9. Decrease unintentional injuries among the MCH populations

Eight State Performance Measures were developed from the nine priorities to complement the 18 National Performance Measures. The eight are:

1. The percentage of women of childbearing age who receive screening and assistance for domestic violence should be increased.

2. Access to preventive oral health services for the Medicaid population of children and youth should be increased.

3. Obesity among women ages 18 to 44 will be decreased.

4. Teen pregnancy birth rates among Hispanic adolescents ages 15-17 should be reduced.

5. All infants born in the state will have a newborn hearing screening prior to discharge from the hospital.

6. The percent of children and youth ages birth through aged 18 who die from unintentional injuries should be decreased.

7. Increase the ratio of primary care providers to the number of children and youth ages birth to twenty-one and women of child bearing age.

8. The percent of children ages birth to twenty-one including CSHCN and women of child bearing age who have access to mental health services, regardless of the ability to pay, should be increased.

Outcome Measures (OM)1 through 5 lead to the issue of achieving a healthy pregnancy and birth outcome. For FY06, the primary efforts of the MCH Program on achieving healthy birth outcomes will be achieved through the Bureau's MCH Campaign and Child and Adolescent Health Programs discussed in III B. The Teen Pregnancy Prevention campaign will continue to work to prevent teen pregnancies, which can lead to low birthweight babies.

For OM 6 the partnerships of Injury Prevention will continue work together to address preventing the deaths of children aged 1-14. The Bureau's Injury Data Surveillance Project produced "An Analysis of the Injury Surveillance Data System in Nevada" in FY 04, which guides the Injury Prevention initiative. The domestic violence and child abuse and neglect activities such as P.A.N.D.A. will continue.

The 2003 Legislative session established a Child Death Review process that involves 2 teams, staffed by DCFS. One team is Executive, on which the Bureau's Women's Health Coordinator sits representing Public Health. It is charged with reviewing child death reports from local teams and making recommendations for state policy changes and outreach campaigns to change behavior. It is comprised of representatives of child death review teams from around the state, public health, vital records, medical personnel, law enforcement, the office of the Attorney General, and a coroner. The other team is Administrative, on which the MCH Chief sits representing Public Health. It is comprised of Administrators from Child Welfare agencies, State agencies of Vital Statistics, Public Health, Mental Health, Public Safety, Child and Family Services, and Clark and Washoe County Departments of Social Services. The purpose of the Executive team as stated in NRS 323B.403-409 is to review the records of selected cases of deaths of children under 18 years of age in the state; review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and die in another state; assess and analyze such cases; make recommendations for improvements to laws, policies and practice; support the safety of children; and prevent future deaths of children. The Administrative team shall review the (Executive team's) report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report. An annual report including statistics and recommendations for regulatory and policy changes is to be produced.

B. STATE PRIORITIES

Nine priorities were identified by the Nevada Year 2005 MCH Needs Assessment.
They include:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.

7. Decrease the incidence of domestic violence among women of child-bearing age.

8. Decrease the risk factors associated with obesity for children and women.

9. Decrease unintentional injuries among the MCH populations.

See the attached Needs Assessment for a discussion of these priorities.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				99	99
Annual Indicator			98.3	99.6	99.0
Numerator			32253	33036	34384
Denominator			32798	33168	34730
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2004

Information is based on data from the Nevada Newborn Screening program contract laboratory - the Oregon Public Health Laboratory, which maintains a computer database of all screening tests submitted and the results. Nevada has always had an excellent participation rate of newborns receiving at least one initial screening prior to discharge. Despite the rapid population growth in the state - hospitals and thier staff remain committed to continuing to

assure all infants have a specimen taken and tested. Thus, it is anticipated that the percent of newborns receiving an initial screen will remain the same.

a. Last Year's Accomplishments

NPM # 1: FY O4. The data source for this measure is state CSHCN Newborn Screening database and birth certificates. This measure is both direct services and population based. FY 04: 99.0

Nevada has contracted with the Oregon Public Health Laboratory (OPHL - a regional laboratory) to do its newborn screening since the early 1970's. OPHL and contracting state agencies developed a tracking and follow-up system that is one of the leaders in the newborn screening community. Protocols and educational materials for the newly adopted Tandem Mass Spectroscopy testing were still being developed. Brochures and practitioner manuals have been adapted and are distributed statewide. OPHL also provides specialist consultation to the laboratory through a contract with the Oregon Health Sciences University, and to primary care providers (PCPs) in Nevada for confirmatory testing and the initiation of treatment. The SHD contracted with a metabolic geneticist to provide ongoing clinical consultation in Nevada to individuals who have been diagnosed with a metabolic disorder and their providers. Infants with an endocrine or hematologic disorder are seen by specialists in the private sector. The CSHCN Program assists with coverage of the definitive diagnosis, lab testing and initiation of treatment. The metabolic specialist saw infants, children and a limited number of adults. Registered dieticians from the Early Intervention clinics (EI), who have received special training in the treatment of these rare metabolic disorders, provided nutrition consultation. The specialist and dieticians offer not only medical management of the disorder, but also counseling relative to the importance of initiation of the special diet prior to becoming pregnant. In the last few years, females with metabolic disorders who wish to become pregnant have returned to the clinic for specialist and dietician services prior to and throughout their pregnancy in order to achieve a healthy birth outcome. Finally, the CSHCN Program worked to ensure all CSHCN with metabolic disorders received the services they need.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nevada's newborn screening program assures access to follow-up services (coverage of confirmatory and on-going testing, consults, specialty food, etc.)		X		
2. Newborn screening cases are automatically referred to CSHCN Program for potential eligiblity and assistance with consults.		X		
3. CSHCN program provides for the purchase of special formula and food products for eligible individuals.		X		
4. CSHCN program provides appropriate referral to a variety of resources and maintains a "NBS" registry.		X		X
5. CSHCN registry triggers annual family update to determine family's status, and assure child is receiving services.		X		X
6. The Bureau continues to manage a statewide program.			X	
7. The Bureau continues to support specialty metabolic clinics in Reno and Las Vegas and arrange for the contracted physician to consult by phone statewide.	X	X		X
8.				
9.				

10.				

b. Current Activities

NPM # 1: FY 05 FY05 Nevada continues to have one of the top programs for Newborn Screening in the nation. 98-99% of Nevada's newborns are screened for Amino Acid Disorders, Organic Acid Disorders, Fatty Acid Disorders, Hypothyroidism, Congenital Adrenal Hyperplasia and Hemoglobinopathies. In addition, 86-88% of newborns receive a second confirmatory screening. The Nevada Newborn Screening program continued to contract with the Oregon Public Health Laboratory (OPHL) to provide expanded testing of infants using Tandem Mass Spectrometry. The implementation of "expanded" testing has increased the number and intensity of follow-up activities for staff, and has also provided an additional element of quality to Nevada's already successful program. Data is obtained through State vital statistics (birth certificates) and Newborn Screening records. (Note: this measure reports screening for all newborns born in the State, regardless of state of residency. There is no data at this time available on newborn screening for those resident infants born out of State.)

The SHD continues to contract with a Metabolic Geneticist to come to the state on a regular basis to see children with inborn errors of metabolism and women of child-bearing age with the same who are considering getting pregnant. Individuals are seen by the clinical Metabolic Geneticist at the E.I. clinics, where they receive not only Geneticist consults, but ongoing access to registered dieticians who have special training in managing these disorders. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

Those individuals who are detected by the program as having a possible metabolic, endocrine or hemoglobin disorder are referred to the Metabolic Geneticist, Endocrinologist, or Hematologist for confirmatory testing and ongoing treatment if necessary. The child is automatically referred to the CSHCN program for continued follow-up services. The CSHCN program provides appropriate referral to a variety of resources and maintains a "registry" of infants found to have a disorder detected by the NBS program. The registry triggers an annual update with the family to determine if the family's status has changed and to assure that the child is still receiving necessary services.

Note: Nevada's newborn hearing screening also meets national goals. See NPM 12)

c. Plan for the Coming Year

NPM # 1: FY06. The SHD will continue to contract with the Oregon Public Health Laboratory (OPHL) to provide "expanded" Tandem Mass Spectrometry testing. This program will provide "state of the art" testing for thirty-one disorders to Nevada's successful program. The OPHL Laboratory contract will continue to contract with metabolic, endocrine and hemoglobin specialists to provide consultation and initiation of testing and treatment. Two specimens will continue to be taken to assure no "missed" cases. When additional information regarding the specificity of the new methodology becomes available, Nevada will evaluate the necessity of two specimens at that time.

The SHD will continue to contract with a Metabolic Geneticist to provide ongoing clinical consultation to children born with metabolic disorders and women of childbearing age with PKU and other metabolic conditions that want to have children. The Metabolic Geneticist will also consult by phone with any physician in the state with a metabolic question; this consultation is a provision of the contract.

All infants detected with an inborn error of metabolism, endocrine or hemoglobin disorder will continue to be automatically referred to the Children with Special Health Care Needs (CSHCN)

program for coverage of needed physician, laboratory and nutrition services. CSHCN refers these babies to the E.I clinics for a full developmental assessment. MCH funded nutritionists based in the Early Intervention clinic will continue to provide ongoing nutrition guidance to metabolic cases and the program

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55	58
Annual Indicator			54.6	54.6	54.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	70	80	85

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

NPM # 2: FY 04. (SLAITS data)

Bureau staff participated in parent empowerment programs sponsored by the Family Ties organization regarding "navigating the benefits system". Grass roots organizations collaborated to promote improved systems statewide, and influenced community agencies to collaborate on a formal plan for the state.

Family Ties staff participated in the Bureau's MCH Needs assessment and interacted with program staff. Meetings clarified areas in which families become frustrated within state systems, and helped in identifying areas of state systems that need improvement. This open exchange helped each side to gain a greater understanding of the other's situation and gain insights into how to best achieve goals that work for both.

The Bureau worked with parent and advocacy groups. Activities included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as develop linkages with other agencies such as Medicaid, Nevada Check Up, Shriner's and the Department of Education, for access to, and coordination of services.

The SHD was awarded a Centers for Medicare and Medicaid Services "Real Choice Systems Change" grant that provides needed resources to assess and assure family participation in decision making for CSHCN. A program manager, a management analyst, and clerical support were hired and immediately moved forward in putting out a "Request for Proposal" for a contractor to perform a statewide needs assessment of the strengths, weaknesses and gaps in service in Nevada's system of care for CSHCN. The Family Ties representative was a part of the evaluation team. The RCSC grant staff were active in partnering with groups such as Medicaid's Continuum of Care office, Mental Health, E.I.Services, Office of Disability Services, Vocational Rehabilitation, Department of Education - Special Education, the Transition Forum - a subcommittee of the Governor's task force and County School Districts. All of these agencies and consumers were involved in the development of the Real Systems Change grant application, and continue to be involved as it is implemented.

The SHD hired a vendor to complete a needs assissment of Nevada's system of long term services and supports for CSHCN and their families. Major needs identified were: a) a difficult and cumbersome financial assistance eligibility process and b) lack of access to services including marginal availability of qualified service providers, physicians, and specialists. Activities are currently being refined to address these two priorities during the one-year demonstration project.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN works with the CSHCN Advisory Council to ensure parent representation in policy development		X		X
2. CSHCN works with Family Ties representatives to develop training to empower parents and CSHCN		X		
3. CSHCN works with Family Ties and Early Intervention (EI) to develop increased Family Ties involvement with EI.		X		X
4. The CSHCN program continues to provide program applicants with information on Family Ties.		X		
5. CSHCN works with RCSC to implement the findings of the CSHCN Needs Assessment, addressing gaps etc.				X
6. RCSC/CSHCN ensures the CSHCN Advisory Council has a role in the development and implementation of systems development for CSHCN pilot projects.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 2: FY 05. Staff will continue to strengthen existing relationships with Family Ties and Early Intervention Services and continues to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County School Districts. These established and new links will be active participants in the RCSC grant needs assessment. Activities directed toward linking Family Ties representatives and E.I. staff will continue. The Bureau staff continues to work on establishing Family Ties representation at the E.I. clinics to better empower families in choosing appropriate services for their child. They will partner with the Resource Parents already in place. Family Ties and CSHCN staff continue to provide cross referral for services. Family Ties information and referrals forms continue to be sent to families applying for CSHCN, and Family Ties readily refers to CSHCN.

The Nevada Advisory Council on CSHCN met, and advised the CSHCN program on pilot development. This group membership includes two-thirds parents and one-third providers. The Nevada Children with Special Health Care Needs Assessment was completed. Parents were an important component of the focus groups utilized during the needs assessment process. The information will form the basis for three pilot projects (funded by the RCSC grant) for systems change for CSHCN; the Council is very involved in their development and will oversee their implementation.

c. Plan for the Coming Year

NPM # 2: FY 06. The Nevada Children with Special Health Care Needs Assessment identified the prevailing needs as improvements in the financial application process and the lack of all provider types. These issues will be addressed by the Nevada Advisory Council on CSHCN, which will oversee and direct the activities of the three pilot projects in Reno, Las Vegas and Elko.

Plans are to continue to strengthen existing ties with Family Ties, Early Intervention Services, Disability Services, Mental Health, Special Education and all of the urban and rural school districts, as well as various community agencies statewide to improve access to services for CSHCN.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				50	55
Annual Indicator			49.1	49.1	49.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	55	60	65	70	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The Real Choice Systems Change grant is being actively implemented. Linkages of CSHCN with physicians, and community programs are being developed to improve access to a medical home and coordination of services. Thus, it is anticipated that this percentage will slowly grow.

a. Last Year's Accomplishments

NPM # 3:FY 04: (SLAITS data)

The Nevada CSHCN program was only able to specifically track and analyze the status of those CSHCN who are either eligible for assistance with payment of their treatment and other services, and/or seen at the multidisciplinary medical specialty clinics. Thus data from the national survey of CSHCN is being used as a base.

The CSHCN program encouraged families to have a "medical home" or "primary care provider" (PCP). Families were asked who the child's PCP is, and the program covered quarterly visits to the PCP if the child's condition remained stable, however, the program does require at least an annual visit with the subspecialist. This encouraged families to continue coordinated services for the optimum well being of their child. Since most of the PCP's for this population are Board Certified Pediatricians, they have embraced this policy and have willingly assumed this responsibility as it has enhanced their ability to see the patient on a continued basis. If a family does not have a PCP, staff works with the family to find an appropriate PCP. PCP's often call CSHCN staff to seek assistance with accessing needed resources. CSHCN staff monitor cases for Medicaid and Nevada Check Up eligibility.

Medicaid and Nevada Check Up programs mandated managed care in the urban areas of the state; in FY 04 a second HMO was added in the north, so managed care is mandated there too. A majority of CSHCN on these programs should have a medical home.

Since the beginning of 2004, the MCH Campaign has been in place and its multi-media component encouraged families to seek a medical home for their children and provide public health education on the value of primary and preventive care. Callers to the IRL for pediatric information were referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH campaign also agreed to see infants and children regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients. The MCH campaign includes a Pediatric outreach campaign.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. CSHCN covers services by the Primary Care Provider (PCP) on a quarterly basis for children eligible for the CSHCN program.		X		
2. CSHCN requires subspecialist consultation at least once a year for eligible children.		X		
3. The CSHCN program encourages families to establish a PCP.		X		
4. The RCSC pilot projects will develop a mechanism in each community to ensure CSHCN have a medical home.		X		X
5. RCSC and CSHCN are working together with Medicaid to increase the EPSDT rate for CSHCN in Nevada.		X		
6. The MCH Campaign community-based vendors in Las Vegas and Reno will establish a medical home for all infants born to women served by the project.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 3: FY05. A goal of the Real Choice Systems Change grant is to increase the EPSDT rate for CSHCN on Medicaid and encourage a medical home. Staff is working with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving these preventive examinations. The Real Choice Systems Change grant and the needs assessment provided needed support to identify data sources that expand to all children, as well as provided state planners with useful information to determine where increased efforts need to be focused.

Since many Medicaid/Nevada Check Up eligible children are enrolled in managed care organizations, medical home data is available through claims records for services delivered through Medicaid and Title XXI claims records. Clear data is still not readily available as the Medicaid program has been in the process of getting certification for its data system, and it is uncertain whether data on CSHCN children enrolled in their program is available.

The MCH Campaign is a source of information for families. This multi-media component encourages families to seek a medical home for their children and provides public health education on the value of primary and preventive care. The multi-media campaign is using Bright Futures to guide the content of the multi-media campaign. Callers to the IRL for pediatric information continue to be referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH Campaign agreed to continue to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients.

A goal of the Real Choice Systems Change grant and its pilots is to ensure a medical home for all CSHCN in Nevada. The Nevada Children with Special Health Care needs assessment documented resources and gaps in primary, mental and dental care as well as specialty care. The CSHCN program continues to establish and cover a PCP for those children who are on the program.

c. Plan for the Coming Year

NPM # 3: FY06. Since one of the goals of the Real Choice Systems Change grant is to

increase the EPSDT rate for CSHCN on Medicaid, staff will continue to work with Medicaid to develop ways of increasing the number of children eligible for and receiving these preventive examinations. Staff will continue to work with Nevada Check Up to develop a system of tracking and reporting "well child" examinations on eligible children enrolled in managed care and especially on those children who are enrolled in their "fee for service" section. The Real Choice Systems Change grant will provide needed support to identify and develop data sources that include all children, and provide state planners with useful information to determine where increased efforts need to be focused.

A goal of the Real Choice Systems Change grant is to ensure a medical home for all CSHCN in Nevada. The Nevada Children with Special Health Care needs assessment documented resources and gaps in primary, mental and dental care as well as specialty care that the Nevada Advisory Council on CSHCN will address via pilot projects.

The MCH Campaign continues to be a source of information for families. The multi-media component will continue to encourage families to seek a medical home for their children and provides public health education on the value of primary and preventive care. Callers to the IRL for pediatric information will continue to be referred to Medicaid and Nevada Check Up for coverage of care and to pediatric providers in their community. Providers who have signed up for the MCH Campaign have also agreed to continue to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients and will continue.

The CSHCN program will continue to establish and cover a PCP for those children who are on the program.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				56	58
Annual Indicator			55.4	55.4	55.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	62	64	66	68

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

NPM # 4: FY04. (SLAITS data)

HD staff worked with staff from Medicaid and Nevada Check Up to more clearly identify CSHCN in all programs. This increased awareness of the need for identifying children with special needs throughout the state has encouraged closer cooperation between agencies and enhanced sharing of available data.

CSHCN staff assisted families in applying for Medicaid and Nevada Check Up by providing information, referral and assistance through the process. CSHCN staff also provided advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for specific services and supplies.

The MCH information line has been a primary component for signing up infants and children for Medicaid and Nevada Check Up. All who call are queried regarding their insurance status. If they have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of Great Basin Primary Care Association (GBPCA). The CSHCN program was also a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The Real Choice Project Team collaborated with the Covering Kids program for a joint media campaign in association with the Nevada Broadcaster's Association (NBA). Covering Kids is a grant funded program housed in the Division of Health Care Financing and Policy (DHCFP). The program's goal is to reduce the number of uninsured children who are eligible for public health care coverage programs - but not enrolled. The media campaign's goals were to increase awareness of available state programs for all children, including those with special needs. The campaign also promoted the Healthy Kids (EPSDT) program and the services available through the CSHCN program. The campaign was guided by a contracted media professional who is also Nevada's Family Voices coordinator and director of Family Ties, a parent-driven group which provides training, information, and emotional support for CSHCN and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN assists families in applying for Medicaid & Nevada Check up Information and Referral.		X		
2. CSHCN advises referred families to request an EPSDT examination for their child.		X		
3. CSHCN provides advocacy for families during the Medicaid and Nevada Check Up appliation process.		X		
4. CHSCN provides information & advocacy with private insurance				

companies to access needed services.		X		
5. CSHCN works with Medicaid to identify CSHCN in Medicaid HMOs to assure appropriate services.		X		
6. CSHCN/RCSC is implementing pilot projects based on the findings of the CSHCN Needs Assessment that will include ensuring medical homes for CSHCN.			X	X
7. The RCSC project continues its partnerships with the Nevada Broadcaster's Association and Covering Kids to increase awareness of available public programs and services available to all children, including CSHCN.			X	
8.				
9.				
10.				

b. Current Activities

NPM # 4: FY 05. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage was also provided to those with private insurance, as well as government programs. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies. CSHCN staff continued to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and followed them until an eligibility determination was made.

The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status. If they did not have coverage, staff refered them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. The MCH information line and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program worked with Nevada Medicaid and Nevada Check Up to increase the number of CSHCN who received an EPSDT examination for their child. Nevada Check Up does not have an "EPSDT" exam in place, but does cover "well child" examinations. Nevada Check Up staff reported that the program does not currently have the necessary resources to initiate a system to track "EPSDT" exams or "well child" exams. They are only able to track "any service" of any type. CSHCN staff is working with Nevada Check Up to develop a means of tracking this type of data in their program.

The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped in July 1, 2004, and more children became eligible for Medicaid.

c. Plan for the Coming Year

NPM # 4: FY 06. CSHCN staff will continue to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources. Assistance through the process and advocacy for service coverage will also be provided to those with private insurance, as well as government programs. Staff will continue to provide advocacy for families with private insurance in providing medical information, especially for rare disorders, in order to justify the need for and coverage of specific services and supplies. CSHCN staff will continue to refer potentially eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made, while providing technical assistance to assure accurate case determination.

The MCH information line will continue to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers are queried regarding their insurance status. If they do not have coverage, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA. If the family does have insurance, CSHCN staff provide valuable assistance via information regarding rare disorders, and medical justification for specialized services and supplies. The MCH information line and the CSHCN program will continue as a referral source for Medicaid and Nevada Check Up, as well as for SSI for the CSHCN.

The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number and tracking capacity of CSHCN who receive an EPSDT, or "well child" examination for their child. Since Medicaid has the capacity to track this data, CSHCN will request an annual report. CSHCN staff will continue to work with Nevada Check Up to develop a means of tracking this type of data in their program.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				75	78
Annual Indicator			75.1	75.1	75.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	82	85	86	87

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

NPM # 5: FY 04. (SLAITS data)

CSHCN staff provided information and advocacy to families and providers attempting to access community-based services. CSHCN staff maintained current information regarding eligibility criteria, asset test criteria, and medical criteria for a variety of programs including Medicaid, Nevada Check Up , Food stamps, WIC, Federally Qualified Health Centers, mental health services, and community organizations. This allowed them to serve as a 'data bank' of information for families in need of high quality, but often expensive, medical care. CSHCN staff also maintained contact with organizations such as the Shriner's in order to provide appropriate referrals and assist with ancillary services as needed. The CSHCN Program collaborated with the Bureau of Early Intervention Services (BEIS) to develop improved procedures for referral and linkage to other government programs and community groups.

Staff continually updated lists of local providers of pharmacy, durable medical equipment, supplies and transportation to assist families with needed services, and was actively involved with arranging for connecting families with appropriate volunteer organizations to receive assistance with "uncovered" services such as lodging, transportation, and "new types of equipment" that are often not covered by most insurance. E.I interdisciplinary clinic staff provided a multi-disciplinary evaluation and referrals to appropriate medical, social and mental health services, as well as referrals for community programs including CSHCN.

Staff also provided training to parent groups to assist them in accessing programs and services. The Family Ties program conducted parent training for families of CSHCN. Staff also met with BEIS and Community Health Nurse staff to discuss the CSHCN program and clarify the services provided. CSHCN staff provided input to parents on how to best "navigate the system" through contact with parent advocacy groups and individual parents. This has proved to be a most satisfying experience on both sides. As a result, families and family organizations are initiating increased contact with CSHCN staff with requests for information.

Staff was hired for the Real Choice Systems Change (RCSC)grant and they immediately set about drafting a "Request for Proposal" for a statewide needs assessment, which was completed. RCSC staff have also connected with representatives of Medicaid, Nevada Check Up, E.I., Mental Health, Office of Disability Services, Vocational Rehabilitation, Department of Education-Special Education, and local County school districts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN continually updates and maintain current referral information on eligibility criteria for Medicaid, Nevada Check Up, Food Stamps, etc.		X		
2. CSHCN maintains current referral lists of local providers for specialists, pharmacy, transportation, etc.		X		
3. CSHCN maintains current referral lists of local volunteer organizations that provide uncovered services.		X		
4. CSHCN provides training to parent groups to assist in accessing programs and services.		X		
5. CSHCN provides information and advocacy to families & providers to access community-based services.		X		
6. The RCSC pilot projects in Elko, Reno and Las Vegas will address community-based systems of care ease of use.				X

7.				
8.				
9.				
10.				

b. Current Activities

NPM # 5: FY05. CSHCN staff provide information and advocacy to families and providers attempting to access community-based services. CSHCN staff updates current lists of local providers for pharmacy, durable medical equipment, supplies, transportation, and lists of local volunteer organizations to access assistance with "uncovered" services such as lodging, transportation and "new types of equipment" that are often not covered by most insurance. CSHCN staff updates information on eligibility criteria for Medicaid, Nevada Check Up, Food Stamps, WIC, Shriner's, Federall Qualified Health Centers, and community organizations in order to provide appropriate referrals and ancillary services as needed.

The SHD was awarded a "Real Choice Systems Change" (RCSC) grant by the Centers for Medicare and Medicaid. This funding supported a statewide needs assessment of the current systems of care for CSHCN, which was completed in January 2005. The RCSC grant supported needs assessment provides a clear outline of gaps in service for CSHCN. State planners are now able to more clearly define areas of "non availability" or "non coverage" as well as those areas of the state lacking or duplicating services. Rural areas of the State are, of course, among the most needy of services, but defining where and what services exist/or are needed, is a real start in solving the problems. The Nevada Advisory Council on CSHCN is bringing together all those stakeholders involved with this population, and will allow for creative solutions to be developed. To attain the broadest degree of stakeholder involvement, the Council includes family members of CSHCN and disabilities advocates from across the state.

The Council is reviewing the needs assessment report, is considering areas of priority, and has decision making responsibilities in the direction and content of project activities.

c. Plan for the Coming Year

NPM # 5: FY06. CSHCN staff will continue to provide information and advocacy to families and providers attempting to access community-based services. As Nevada is still one of the fastest growing states, there is constant change in provider partnerships, addresses and availability. Thus, it is important to continually update resource lists statewide. CSHCN staff will maintain and update current lists of local providers for pharmacy, durable medical equipment, and supplies. CSHCN will continue to maintain lists of local volunteer organizations to access assistance with "uncovered" services such as lodging, transportation and "new types of equipment" that are often not covered by most insurance. CSHCN staff will update information on eligibility criteria for Medicaid, Nevada Check Up,Food Stamps, WIC, Shriner's, Federally Qualified Health Centers, and community organizations in order to provide appropriate referrals and ancillary services as needed.

The Nevada Advisory Council on CSHCN has brought together stakeholders involved with the CSHCN population, and will work for the development of creative solutions. The Council will continue to include family members of CSHCN and disabilities advocates from across the state. The Council has reviewed the needs assessment report and will help determine areas of priority and will have decision making authority in the direction and content of project activities, including the pilot projects.

The emerging network of parent groups, advocacy groups and other stakeholders has expanded the opportunity to enhance services for CSHCN in Nevada. Staff will work on the development of a strategy for ensuring Council involvement in the project during the project period, and also in maintaining Council involvement in issues affecting CSHCN in Nevada after the funded project activities have been completed.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				6	10
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	10	15	20	25

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The Real Choice Systems Chang grant is being implemented and various parent groups and community agencies are working together to develop and improve transition services statewide. Staff is working with the Department of Education and parents to provide technical assistance. In addition, staff has developed a web-site and participates in local publications to educate the public about available services. Thus, we anticipate gradual improvement in this area.

a. Last Year's Accomplishments

NPM # 6. FY04. 5.8 (SLAITS data)

CSHCN staff, in collaboration with Family Ties, provided information and advocacy for families to access federal, state and community organization assistance, which included transition

support. CSHCN staff continued to counsel parents about the PCP's role to assist with referral to adult health care providers and ensure the transfer of medical records. CSHCN staff and Family Ties representatives continued providing parents with information regarding Individualized Education Plans (IEP) for appropriate vocational training of CSHCN, and encouraged families to be involved with the educational plan for their child.

The State Health Division (SHD) was awarded a Real Choice Systems Change (RCSC) grant from the Centers for Medicare and Medicaid Services. The SHD hired a vendor to complete a needs assessment of Nevada's system of long term services and supports for CSHCN and their families by January 2005. Program staff coordinated participation of stakeholder groups and interested parties, including state and local agencies, public and private service providers, advocacy groups and networks, and parents and families during all phases of the needs assessment.

The Real Choice project team collaborated with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. They also collaborated with another RCSC project team which was awarded to the State Office of Disability Services in FY 2003. The two programs work together to coordinate the scopes of work for both RCSC grants to best assist adolescents and young adults in their transition to all aspects of adult life, including education, employment, and housing.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN counsels parents regarding having PCP assist with referral to adult health care providers.	X	X		
2. CSHCN provides information for families regarding SSI eligiblity, Medicaid eligibility, etc.		X		
3. CSHCN provides family information regarding IEP for appropriate vocational training of CSHCN.	X	X		
4. CSHCN encourages families to be involved with the educational plan for their child.	X	X		
5. PCP and families are given information on adult providers to work with specific conditions.	X	X		
6. PCP and fammilies are given information where in community ancillary services may be available.	X	X		
7. RCSC works with the Office of Disability Services to ensure an action plan for the transition of CSHCN to adult services is created.			X	
8.				
9.				
10.				

b. Current Activities

NPM # 6: FY05.

The Real Choice Systems Change project vendor completed the statewide needs assessment. The assessment included focus groups consisting of families of CSHCN.

The needs assessment identified many mental and other health care providers throughout the

state and developed an inventory for Nevada's CSHCN and their families.

In February 2005 RCSC staff developed and launched the CSHCN web-site at: http://health2k.state.nv.us/cshcn.

This site contains information for families that assists with applications and resources. Plans are to add information relevant to different age groups of CSHCN.

The RCSC project team, along with the CSHCN program, Family Ties' - CMS funded resource directory project, and the Bureau of Early Intervention Services (BEIS) worked to augment the current central resource directory (Project ASSIST). Project ASSIST is currently a link on the CSHCN webpage (which posted November 2004); the Family Ties directory will be added once it launches. These resources will allow CSHCN, their families, advocates, and providers 24 hour access to a current database of available services and supports for all of Nevada's CSHCN. Transition support and transportation resources are already included on the CSHCN website (http://health2k.state.nv.us/cshcn). Staff contacted the Department of Education and are working on a developing a collaborative relationship to assist CSHCN to improve planning for the future.

c. Plan for the Coming Year

NPM # 6: FY06.

CSHCN staff will continue to provide education for families about the importance of their input for the medical care of their children, how to access community resources, and also suggest ways they can engage the schools in planning for the educational and training needs of their children for the future. Parents will be advised of the importance of the Individual Education Plan (IEP) for their child, and how their input is vital to the planning for their child's future. This will result in parents' improved understanding of how they can be empowered by the knowledge they have about their child's needs and capabilities. The information will enable parents to realistically plan for their child's move to adulthood in areas such as independent living and residential care. It will also prompt parents to plan for the financial stability of their child. Families will continue to be referred to Family Ties of Nevada for needed support and "system navigation" guidance.

The Nevada Advisory Council on CSHCN is strategizing how to coordinate efforts with the Developmental Disabilities Council, Vocational Rehabilitation, the Strategic Plan Accountability Committee, Family Ties' pilot project, Nevada PEP, and the Northern Nevada Transition project at UCEDD. In addition, the Council kept watch over the changing conditions of Senate Bill 22 of the 2005 Legislature, which passed. It will affect transitioning youth services in Nevada by establishing an Interagency Advisory Board on Transition Services to study persons with disabilities who are transitioning from secondary school to adult living. The Council includes state and local special education coordinators who will be invaluable in the Council's efforts to address issues for youth entering adulthood.

The RCSC staff will be adding information to the web site relative to transition, as well as updating any information regarding resources that may have changed.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	78	79	78	75
Annual Indicator	78	66.0	74.4	74.4	74.5
Numerator		28692	33307		31160
Denominator		43473	44768		41826
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	76	77	79	80

Notes - 2002

This data is from the state by state report: US, National Immunization Survey, Q3/2001-Q2/2002, produced by CDC.

Notes - 2003

This data comes from the CDC produced National Immunization Survey for Nevada for 7/2/2002 - 6/30/03. The numerator and denominator were not given.This data was given to the Bureau by the State's Immunization Program.

a. Last Year's Accomplishments

NPM # 7: FY 04: Percent of 19 to 35 month olds who have received full schedule of immunizations. FY 04: 74.5

Reporting of this measure is from the U.S. National Immunization Survey. This goal is always impacted by the state's rapidly growing population and ever increasing birth rate. This measure is a population-based service that targets infants and young children. Although this National Performance Measure is reported to age 35 months, the initiative itself serves older children including those to age 5 in the WIC program.
MCH funding supported immunizations offered in Bureau of Community Health community health nursing clinics as well as in MCH supported Washoe County District Health Department clinics.

There is a very strong link between Nevada's Immunization (in BCH) and WIC programs. All WIC clinics routinely request WIC participants bring in their immunization records as part of the WIC Certification and Recertification clinic visit. WIC staff review the immunization records to determine if participants are current with the appropriate immunizations. If participants are not current with their immunizations, they are referred to appropriate providers. The effort to integrate the WIC clinics into the State Immunization Registry along with the Community Health Nurse Clinic sites, private providers, health districts, hospitals and some HMOs started in FY02. This project is ongoing. During the prior year, the Nevada Immunization Program transferred the Immunization Registry to new software, rendering the old links for the WIC clinics obsolete. The WIC program and the Immunization Program continued to work together to develop the new links needed for the WIC Program in the Immunization Registry software.

Once the links are in operation, the Nevada Immunization Program has agreed to provide training to the WIC clinics on how to access and use the new Immunization Registry. In the meantime, the new WIC clinics are starting to be linked into the Nevada State Health Division network backbone using T-1 lines. Those WIC clinics with existing ISDN will be upgraded to T-1 lines in the future. This will provide smoother access to the Immunization Registry through the Health Division Intranet.

WIC clients in Washoe County are also able to keep track of their immunizations by way of the Health Passport Project (HPP) smart-card, although very few have taken advantage of this opportunity. The smart-card project was launched in Washoe County in June 2000 and is expanding the use of the Electronic Benefit Transfer (EBT) card into the Las Vegas area for the delivery of benefits. The EBT card has the capacity and is already designed to store the WIC clients' immunization records. WIC will explore the possibility of downloading the immunization records directly from the Nevada Immunization Registry onto the EBT card.

The Nevada WIC hot-line number is 1-800-8 NEV WIC. WIC is looking at another provider that would be able to provide bilingual services 24/7.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue developing WIC clinic linkage with State Immunization registry and WIC marketing campaign with Immunizations.		X		
2. Continue referral of WIC participants to immunizations for those who need them. Implement WebIZ as funding allows.		X		
3. Continue funding Community Health Nursing Clinics services which include immunizations.		X		
4. Include information on immunizations to women who access assistance through the MCH Campaign.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 7: FY 05. Activities begun in FY 04 continued into FY 05. There is a very strong link between Nevada's Immunization (IN BCH) and WIC programs. All WIC clinics routinely request WIC participants bring in their immunization records as part of the WIC Certification and Recertification clinic visit. WIC staff review the immunization records to determine if participants are current with the appropriate immunizations. If participants are not current with their immunizations, they are referred to appropriate providers. The effort to integrate the WIC clinics into the State immunization registry along with the Community Health Nurse Clinic sites, private providers, health districts, hospitals and some HMOs started in FY02. This project is ongoing. During the prior year, the Nevada Immunization Program transferred the Immunization Registry to new software, rendering the old links for the WIC clinics obsolete. The WIC Program and the Immunization Program continue to work together to develop the new links needed for the WIC Program in the Immunization Registry software. Once the links are in operation, the Nevada

Immunization Program has agreed to provide training to the WIC clinics on how to access and use the new Immunization Registry.

In the meantime, the new WIC clinics are starting to be linked into the Nevada State Health Division network backbone using T-1 lines. Those WIC clinics with existing ISDN will be upgraded to T-1 lines in the future. This will provide smoother access to the Immunization Registry through the Health Division Intranet.

The Nevada WIC hot-line number (1-800-8 NEV WIC) is the number given for information with the Nevada Broadcaster's PSA campaign for immunizations. This line provides some bilingual services. WIC is looking at another provider that would be able to provide bilingual services 24/7. On occasion, the Nevada WIC Program and the Nevada Immunization Program share the cost of a joint marketing plan in selected areas of the State. These activities continued in FY 05.

MCH funding supports immunizations offered in the BCH community health nursing clinics as well as in the MCH supported Washoe County District Health Department clinics.

The Bureau maintained a Maternal and Child Health IRL, which is staffed by a bilingual operator. Callers requesting information about immunizations are referred to local clinics that give immunizations in their area.

c. Plan for the Coming Year

NPM # 7: FY 06. Nevada's WIC program will complete the link with the State's Immunization Program within the Bureau of Community Health (BCH). All WIC clinics will be integrated into the State Immunization Registry along with the Community Health Nurse Clinic sites, private providers, health districts, hospitals and some HMOs. When completed this will allow for fewer missed opportunities since WIC clinics will have the ability to do real time searches of children's immunization records. Depending on the location of the WIC clinic, they are able to send a family to a nurse to obtain needed immunizations on site, or will refer the family to a site for immunizations. The Nevada WIC hot-line number (1-800-8 NEV WIC) is the number given for information with the Nevada Broadcaster's PSA campaign for immunizations. This line provides some bilingual services. WIC is looking at another provider that would be able to provide bilingual services 24/7. On occasion, the Nevada WIC Program and the Nevada Immunization Program share the cost of a joint marketing plan in selected areas of the State. These activities are planned to continue in FY06.

WIC clients in Washoe County are also able to keep track of their immunizations by way of the Health Passport Project (HPP) smart-card, although very few have taken advantage of this opportunity. The WIC program is expanding the use of the Electronic Benefit Transfer (EBT) card into the Las Vegas area for the delivery of benefits. The EBT card has the capacity and is already designed to store the WIC clients immunization records. WIC will explore the possibility of downloading the immunization records directly from the Nevada Immunization Registry onto the EBT card.

A cost benefit analysis of the various options for the EBT project was completed in July 2003 by an independent contractor. The final recommendation was to rollout the smart-card statewide. Additional funding was received from USDA to rollout the smart-card to seven clinics and 90 stores in Las Vegas, Nevada. This will increase the number participating in HPP to 75% of the WIC participants statewide. This phase of the project will be completed in July 2005 and will add 28,000 WIC participants as EBT users. Approximately 8,000 participants are using the EBT card in Washoe County. Additional funding will be requested in this fiscal year to complete the rollout to the remaining 7 clinics and 50 stores in Las Vegas. The balance of the State would be rolled out in the following year. The Health Passport Project received a strong

endorsement from Richard Carmona, Surgeon General of the United States during his visit to Washoe County District Health Department in May 2004. Immunizations remain a priority for WIC nationally and in Nevada.

MCH funding will continue to support immunizations offered in the BCH community health nursing clinics as well as in the MCH supported adolescent clinics.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	37	34	33	30	27
Annual Indicator	33.8	30.6	27.1	27.5	26.7
Numerator	1270	1214	1174	1257	1266
Denominator	37579	39689	43328	45749	47362
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26	25	24	24	24

a. Last Year's Accomplishments

NPM # 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years. FY04: 26.6 per 1,000 (preliminary Data).

The data for FY 04 is from state birth certificates, CHDR database. This measure is population based.

The main activities for Nevada's teen pregnancy prevention initiative included community involvement through community organizations, the Nevada Statewide Coalition Partnership, a network of prevention coalitions located in ten of Nevada's seventeen counties, workshops for parents of adolescents, and the continuation of the Governor's Youth Advisory Council (GYAC), which identified teen pregnancy prevention one of its top three priorities.

Due to Congress reallocating funds to the States based on Census 2000 data, Nevada was given nearly twice as many Abstinence funds in FY 04 than FY 03. The majority of the increased funding was made available to community organizations. These funds were targeted towards the Hispanic/Latino populations of Clark and Washoe counties, the counties with the highest rates of teen pregnancy.

Some funds were also used to promote parental communication and connectedness throughout the State. Two subgrants were administered to provide training for parents in the various issues of teen maturation and how to talk to their children. One program for example,

Positive Choices, Positive Futures, has been very effective in southern Nevada.

Materials in the Teen Pregnancy Prevention Resource Center were made available to community organizations and other interested parties upon request. The State Health Division maintains the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continued to seek other opportunities to work collaboratively with various communities. As an example, staff gave technical assistance to the Clark County Teen Pregnancy Prevention Coalition in order to assist in their annual needs assessment. An initiative to combine efforts to prevent STDs, HIV and teen pregnancy by addressing common risk factors as well as promoting protective factors was continued. This initiative (Stakeholder) is a collaboration between the State Department of Education, the Division of Mental Health and Developmental Services, the Division of Child and Family Services, the Welfare Division, and the State Health Division's Bureau of Family Health Services, Bureau of Community Health, and Bureau of Alcohol and Drug Abuse.

The media campaign with Nevada Broadcasters Association continued until September 2004.

The GYAC continued their "Abstinence Works!" presentations on a limited basis. The GYAC evaluated the program. They felt it was a program worth keeping but decided to revise its content to make it more up to date, to include principals from evidence based programs, and to strengthen the evaluation. AbstinenceWorks! was seen by 624 youth in Nevada during FY 04.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support community coalitions and organizations including those serving minority populations by making federal Abstinence-only Education funds available for local projects and developing partnerships with the GYAC.		X		
2. GYAC's continued commitment to teen pregnancy prevention as a top priority.			X	
3. Development and implement teen pregnancy prevention programs specifically targeting Hispanic/Latina populations in Washoe and Clark Counties.		X		
4. Continuation of the statewide media campaign with NBA promoting sexual abstinence until marriage.			X	
5. Continuation of workshops for parents of adolescents on importance of healthy sexuality, including those for Hispanic parents.		X		
6. Continue statewide "Abstinence Works?" or its successor to children ages 9-14. Also offered in Spanish.		X		
7. Continued maintenance of teen pregnancy prevention web page and resource center.			X	
8. Continue support teen health clinics in Clark and Washoe Counties.	X			
9.				
10.				

b. Current Activities

NPM # 8: FY05. The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community coalitions, a statewide media campaign, workshops for parents of adolescents, more collaboration between state agencies, and the continuation of the GYAC which has identified teen pregnancy prevention as one of its top 3 priorities.

Nevada continued to receive increased Abstinence Education funds in FY05. The majority of the increased funding is being made available to community coalitions and non-profit organizations through a RFP process. Two subcontracts have been awarded to support programs that educate parents of adolescents, and two are supporting programs that focus on teen pregnancy prevention for Hispanic/Latino adolescents in Nevada's two most populous counties, Clark (including Las Vegas) and Washoe (including Reno and Sparks).

Staff continue collaborating with local programs such as the Clark County Teen Pregnancy Prevention Coalition (CCTPPC). Bureau staff are actively involved in the CCTPPC and are currently working on a needs assessment report for FY 05. The program is also continuing to support two teen clinics located in Clark and Washoe Counties. In addition SHD staff are collaborating with other state programs to collectively address adolescent reproductive health. For example, the SHD is collaborating with the State Department of Education, the State Department of Mental Health and Developmental Services, the State Welfare Division, and the State Division of Child and Family Services to reduce the incidence of STDs, HIV and teen pregnancy. This group (called the Stakeholders) is producing an action plan to outline their collaboration on reproductive health for youth.

The contract with Nevada Broadcasters Association for the teen pregnancy prevention media campaign is being renewed for another year. Bureau staff is reviewing other states' media campaigns to determine if any would be appropriate for Nevada that could be used or reproduced. The Nevada State Health Division is exploring other creative media outlets such as laundromats, movie theaters, stores, and other places youth and their parents might frequent.

The GYAC has been evaluating their "Abstinence Works!" presentation for effectiveness and has decided to continue the program with revisions. Based upon their evaluation and review of other evidence based programs, the GYAC in conjunction with Bureau staff has been updating "Abstinence Works!" to incorporate evidence based principals, updated statistics and relevance, and an improved evaluation.

Bureau staff, the MCHAB and the GYAC are currently working with the Clark County School District to improve their sex education curriculum. Technical assistance and education materials being are provided.

Materials in the TPP Resource Center are available to community organizations etc. The TPP website is maintained at http://health2k.state.nv.us/CAH/teenpregprevention.htm.

c. Plan for the Coming Year

NPM # 8: FY06. The main activities for Nevada's teen pregnancy prevention initiative will include the continuation of community involvement through community coalitions, a statewide media campaign, workshops for parents of adolescents, more collaboration between state agencies, and the continuation of the GYAC which has identified teen pregnancy prevention as one of its top 3 priorities.

Nevada will continue to receive Abstinence Education funds in FY06. The majority of the funding will be made available to community coalitions and non-profit organizations. Current subcontracts will be continued. These include two subcontracts to support programs that

educate parents of adolescents, and two that support programs that focus on teen pregnancy prevention for Hispanic/Latino adolescents in Nevada's two most populous counties, Clark (including Las Vegas) and Washoe (including Reno and Sparks). One additional grant will be awarded to support the replication of the Positive Choices, Positive Futures as modified by the Southern Nevada Area Health Education Center or a like program in Carson City which has the highest Hispanic birth rate for adolescents ages 15-17 out of the rural counties.

Materials in the TPP Resource Center will be updated and made available to community organizations and other interested parties upon request. The SHD maintains the State TPP website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public as well.

Bureau staff will continue to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Staff will continue collaborating with local programs such as the Clark County Teen Pregnancy Prevention Coalition. The program will also continue to support two teen clinics located in Clark and Washoe Counties. In addition SHD staff will continue to collaborate with other state programs to collectively address teen pregnancy prevention. For example, the SHD will continue collaborating with the Stakeholders group to reduce the incidence of STDs, HIV and teen pregnancy.

The contract with Nevada Broadcasters Association for the teen pregnancy prevention media campaign will be renewed. The Nevada State Health Division will also support the statewide media campaign by exploring creative media outlets such as movie theaters, laundromats, etc.

The Governor's Youth Advisory Council will continue to implement their revised "Abstinence Works!" This program will be promoted vigorously in FY 06. The GYAC will continue to evaluate it as well as explore additional evidenced based programs that could be implemented. presentation. In addition Bureau staff, the MCHAB and the GYAC will continue to support sex education efforts of the Clark County School District as well as other school districts in Nevada.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	40	41	42	43	38
Annual Indicator	37.5	37.5	37.5	32.5	32.5
Numerator	11209	10760	11179		
Denominator	29891	28693	29810		
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	38	38	38	38	38

Notes - 2003

This measurement is take from a statewide dental screening of third-graders conducted in 2003. The "Miles for Smiles" mobile dental bus and Saint Marys's "Take Care A Van" traveled to selected schools throughout the state to estimate sealant prevalence. A convenience sample was selected utilizing geographic diversity and socioeconomic status.

Notes - 2004

This survey was not updated in 2004. The next screening is scheduled for FY 06.

a. Last Year's Accomplishments

NPM # 9: FY 04. Percent of third grade children who have received protective sealants on at least one permanent molar tooth. FY 04: 32.5%

For FY 04, the percent is 32.5%. The numerator is the number of 3rd grade children with a sealant. The denominator was the number of 3rd grade children in the state during the year. Reporting of this measure is an estimate from a statewide dental screening of third-graders conducted in 2003 using the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey (BSS). This same screening of children enrolled in third grade will be conducted again in 2006 and every three years thereafter.

In 2004, the SHD worked with the partners on the statewide dental sealant project to resolve a number of significant challenges. There are 17 school districts in Nevada, of which Clark County School District (Las Vegas and Henderson) is by far the largest. The Clark County School District had legal requirements that other school district did not have. Determining how best to meet these requirements was extremely challenging. A Memorandum of Agreement between the Clark County School District, and the Board of Regents, University and Community College System of Nevada on behalf of the University of Nevada, Las Vegas School of Dental Medicine and Community College of Southern Nevada Dental Hygiene Program was finally agreed on in December 2003. Signatures were obtained from the General Counsel for the University and Community College System of Nevada, the President of the University of Nevada Las Vegas, the Dean of the UNLV School of Dental Medicine, the Director of Patient Care Services at the UNLV School of Dental Medicine, the President of the Community College of Southern Nevada, the Department Chair of the Dental Science Programs at the Community College of Southern Nevada, the Director of Community Outreach at Saint Mary's Health Network, the Southern Region Coordinator for Seal Nevada and a designated Clark County School District Representative.

On March 25, 2004, the State Board of Dental Examiners finally approved regulations allowing dental hygienists in public health settings to place sealants without a prior diagnosis by a licensed dentist. This change to Nevada Administrative Code (NAC) took almost two years to complete.

Once the change to NAC was approved, a second letter to recruit volunteers to participate in the program was sent to every Nevada licensed dental hygienist residing in the State. Additional manpower for the sealant program was obtained when the University of Nevada Las Vegas (UNLV) School of Dental Medicine agreed to have dental students participate in the program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of Service

Activities	DHC	ES	PBS	IB
1. Collaborate with Saint Mary's Foundation, Community College of Southern Nevada, UNLV School of Dental Medicine and the Nevada Dental Hygienists' Association on the Sealant program.		X		
2. Identify target school according to established protocols.		X		
3. Schedule schools, volunteer dentists, dental students, dental hygienists and dental hygiene students to staff the sealant services		X		
4. Collect, analyze and report data on sealants.				X
5. Promote sealant coverage by Medicaid and Nevada Check Up providers and by the private practice community.			X	
6. Identify additional resources for the sealant program.		X		
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 9: FY 05. During 2005, the State Oral Health Program continued to provide assistance in the coordination of school-based dental programs in Nevada. $65,000 was obtained through the HRSA State Oral Health Collaborative Systems grant to strengthen and expand school-based dental sealant programs in Nevada.

In addition, a significant challenge for the school-based sealant program in southern Nevada (obtaining care for children identified as needing restorative treatment) was resolved with the establishment of the 1DAY program. This program is a collaborative effort of the members of the Community Coalition for Oral Health in Las Vegas. Dentists who participate in the 1DAY program agree to provide oral health services to uninsured children on a pro bono basis. Children who are uninsured and who are identified as needing restorative treatment by the school-based dental sealant program are referred to the 1DAY program for follow up care.

c. Plan for the Coming Year

NPM # 9: FY 06. The SHD will continue to partner with St. Mary's Foundation, the Nevada Dental Hygienists' Association, the UNLV School of Dental Medicine and the Community College of Southern Nevada Dental Hygiene program in the statewide dental sealant project described in FY05.

The SHD will coordinate the scheduling between the schools and the volunteers. The CDC cooperative agreement funds a half-time position to coordinate the statewide dental sealant program.

The SHD will continue to identify additional resources for the dental sealant program.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.5	4.2	4.2	3	2
Annual Indicator	6.4	2.3	2.8	4.3	4.0
Numerator	26	10	13	21	20
Denominator	404202	432490	466923	483936	497677
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.4	2.3	2.2	2

a. Last Year's Accomplishments

NPM # 10: FY 04. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. FY 04: 2.61

The data for FY 04 for this performance measure is from State vital statistics provided by the CHDR, Bureau of Health Planning and Statistics. This is preliminary data. This measure is a population-based measure that impacts children from age one through age 14.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, Clark County Health District, Washoe County District Health Department, SAFE KIDS Clark County, SAFE KIDS Washoe County and the Nevada Office of Traffic Safety.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

The Governor's Youth Advisory Council voted to focus on youth violence issues as one of its 3 priorities for the coming year. They provide age-related input for targeting areas of injury prevention in driver safety, of which they are very concerned. The Council, all of whom are appointed by the Governor, meets 4 times a year and is a forum for presentations and debate on youth safety issues.

The Injury Prevention Program participated in the Nevada Occupant Protection Assessment that was conducted by the Nevada Office of Traffic Safety. This assessment has been published and has provided the state with recommendations for highway safety plans relating to seat belts and child safety seats.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. The Injury Prevention Program performs data surveillance on Motor Vehicle Crashes of children aged 14 years and younger.				X
2. The Injury Prevention Program is involved in the Highway Safety Summit and the creation of the Nevada Traffic Safety Task Force.			X	
3. The Injury Prevention Program is involved in the Child Passenger Safety Task Force.			X	
4. The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Office of Traffic Safety.				X
5. The Injury Prevention Program applied for funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years including injury surveillance.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 10: FY 05. The Injury Prevention Program was involved in the Highway Safety Summit and the creation of the Nevada Traffic Safety Task Force. The Traffic Safety Task Force was organized by the Nevada Department of Transportation. The goal of the Task Force is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program is also involved in the Child Passenger Safety Task Force, which is a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

The Injury Prevention Program applied for funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years.

c. Plan for the Coming Year

NPM # 10: FY 06. The Injury Prevention Program will be involved in the Nevada Traffic Safety Task Force, which has already been created but will be formalized in fiscal year 06. This Task Force will be organized by the Nevada Department of Transportation. The goal of the Task Force is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a recommendation made in the Occupant Protection for Children

Assessment, and is organized by the Nevada Office of Traffic Safety Office. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

The Injury Prevention Program applied for funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The Nevada State Health Division will be notified on the outcome of this grant application in fiscal year 06.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	53	57	57	59	63
Annual Indicator	58.3	53.0	58.3	61.2	64.8
Numerator	7004	16588	19146	20564	22593
Denominator	12015	31297	32841	33605	34840
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66	67	68	69	70

Notes - 2002

As in years past this data represents the percent of WIC mothers breastfeeding at birth applied to the total number of births. It is hoped that data for all births will be collected on the newborn screening lab slips in FY 04.

Notes - 2004

This data is based on Newborn Screening testing data. Nevada mandates that all infants receive a newborn screening - one prior to hospital discharge and another a few weeks after discharge. Staff have been working with birthing hospitals to improve data collection on babies and on breastfeeding. Hospital staff report that this information is helpful to them in enabling them to improve their quality assurance programs in the maternal and child health area for the JCAHO survey of facilities. Nevda issued a first report to the birthing hospitals in the summer of

2005 that enables facilities to guage how well they are doing.

a. Last Year's Accomplishments

NPM # 11: FY 04: Percentage of mothers who breastfeed their infants at hospital discharge. FY 04: 65.1

Data source: Centers for Disease Control Pediatric Nutrition Surveillance System and State Newborn Screening slips.

Data regarding breastfeeding upon discharge was not readily available. However, hospitals did report the they anticipate setting up systems to better collect the information as JCAHO is suggesting the facilities use this type of data as part of their quality assurance program.

62%, of WIC mothers were breastfeeding upon discharge from the hospital in FY 04. Data is from CDC's nutrition surveillance system, and reports from Newborn Screening blood spot slips which have a place to indicate whether the infant was being breast fed at the time. The goal for breastfeeding initiation nationwide is 75%.

In FY04, WIC clinic staff education continued to be a priority for WIC. There were quarterly staff trainings as well as a quarterly newsletter. The WIC Breastfeeding Coordinator was involved with Task Force activities statewide and provided information and assistance to organizations providing lactation services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC partners with hospitals for more accurate breastfeeding data				X
2. Disseminate statistics to lactation consultants etc. to target activities in identified areas.				X
3. WIC continues to promote breastfeeding and provide breastfeeding education by lactation specialists and breast pumps in clinics statewide.		X		
4. WIC networks with other lactation consultants and healthcare providers statewide to promote breastfeeding.		X		
5. WIC supports the breastfeeding "peer counselor" program				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 11: FY 05.

Data Source: Nevada Newborn Screening Program

The Nevada Newborn Screening Program collects feeding data on infants being screened for metabolic disorders. The program database indicates that out of a total of 34,730 births (provisional), 99% of newborns were screened (34,384). Of these, there were entries relative to breastfeeding on 65% of the infants. The program provides for a second screening on infants (and approximately 80% of infants receive a second screening a few weeks after hospital

discharge). The data submitted indicates that of the initial 65% of infants reporting breatfeeding at hospital discharge - 83% of them are still breastfeeding at the time of the second sample approximately two weeks post discharge.

The Breastfeeding Coordinator attends conferences and workshops, provides information and assistance to local organizations involved in breastfeeding support and remains active in breastfeeding task forces statewide. In addition, she began work on a self-study module for clinic staff which, at its completion by staff members, will ensure a minimum competency level for breastfeeding knowledge within the clinics.

Semiannual trainings are held and select WIC staff from each local agency statewide receive advanced lactation training, earning the designation of Certified Lactation Counselor. 75% of those counselors are also fluent in Spanish, which addressed the needs of the growing Hispanic population.

The Healthy People 2010 goals also specified breastfeeding duration rates for the infants first year of life (50% at 6 months and 25% at one year). WIC purchased 75 hospital grade electric breast pumps to initiate a pump loan program for participants who would otherwise have had to discontinue breastfeeding due to illness or other extended separations.

c. Plan for the Coming Year

NPM # 11: FY 06.

In FY06 the state WIC Breastfeeding Coordinator will continue to work with the Newborn Screening Program (NBS) (also in the Bureau) to improve and incorporate their breastfeeding data with the NBS data and will work on the development of a report that facilities can use as part of their own quality assurance process while improving Nevada's data capacity. Staff will also work with the NBS contract laboratory to develop the capacity to report racial/ethnic data on the NBS breastfeeding report.

The Center for Health Data and Research (CHDR) in HP&S can match NBS and WIC data for an unduplicated count. This will represent a more accurate initiation rate statewide as greater than 98% of infants born in Nevada are included in that screening. In addition, it will be possible to determine initiation and short term duration rates by geographic regions and ethnicity statewide.

To increase initiation rates statewide the Breastfeeding Coordinator, in collaboration with Newborn Screening, will offer continuing education credit courses to staff who work in maternal-child healthcare settings such as hospitals and clinics. Providing accurate, updated information will facilitate staff efforts to assist new mothers with breastfeeding and direct them to available referral resources in the community after discharge. One of the deterrents to breastfeeding duration is lack of adequate and knowledgeable support and follow up in the immediate days following hospital discharge. Results from the second screening at two weeks of age will be used to identify the percentage of women who have discontinued breastfeeding in those early days after discharge. Staff will work with hospital nursery staff to encourage the completion of the newborn screening forms at the hospital, and encourage providers to complete the feeding portion of the form accurately at the time of the second NBS specimen collection.

Initiation and short term duration rates gathered from the surveys will be disseminated to lactation consultants and health care personnel involved with newborns statewide. Regions and population groups identified to have lower rates can be targeted for additional breastfeeding

promotional and educational activities as well as the possibility for improved support services within the community.

Ongoing activities for FY06 include increasing the number of WIC staff attending advanced lactation training, facilitating changes in the prenatal breastfeeding education provided in the clinics and purchasing more hospital grade electric breast pumps. All staff will continue to receive training at least semiannually and the newsletter and other current educational and promotional items will continue to be made available.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	35	80	85	94
Annual Indicator	27.2	34.5	90.8	94.3	92.5
Numerator	8200	10798	29180	30958	31815
Denominator	30130	31297	32121	32834	34384
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	96	96	97	97

Notes - 2004

The Nevada Newborn Hearing Screening program has been very successful in getting newborn infants screened for hearing deficits. Problems have been encountered in assuring the follow up component. Families who have private insurance (or do not need financial assistance) rarely respond to letters sent offering CSHCN assistance. Attempts to follow up with physicians have been unsuccessful, with HIPAA being sited as the primary reason - along with the lack of time and/or funding to cover the time needed for follow up activities.

a. Last Year's Accomplishments

NPM # 12: FY04: Percentage of newborns who have been screened for hearing before hospital discharge. FY 04: 92.5

Effective January 1, 2002, the Nevada Legislature mandated newborn hearing screening for all hospitals that provided birthing services for more than 500 births per year.

Newborn Hearing Screening was implemented in Nevada on January 1, 2002 in all hospitals with at least 500 births a year. Staff met with hospitals mandated to provide hearing screening and mutually developed a data collection matrix and reporting protocol. Hospitals reported the number of infants screened, as well as data on infants who needed referral for further

evaluation and treatment. Hospitals were provided with information so referrals would be made to the E.I. multidisciplinary clinics to ensure that all babies would be able to access services. Staff at some hospitals continued to encounter some problems with equipment and staff training. Facilities submitted data quarterly relative to the number of infants screened and those who were referred for further evaluation.

The Bureau was awarded a grant for the implementation and expansion of a Newborn Hearing Screening program. This grant allowed the Bureau to hire a full time position to provide follow back services to assure that all babies detected as needing further evaluation and treatment received those services in a timely manner. The individual who was hired to fill the FTE left the positon after six months, thus delaying the follow up acitivies planned. Due to limited funding available in the grant, it was decided to hire a 3/4 time contract employee to fill the position and "catch - up" follow up activity resumed. As a result, the three month diagnosis timeline, and six month treatment timeline was not always met.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN staff works with hospitals to receive NBHS data quarterly if not monthly to facilitate follow-up of identified infants.			X	X
2. CSHCN staff works with hospitals to refer "failed" cases to their medical home and Early Intervention Services.		X		
3. CSHCN staff compile data for the mandated annual report to the Governor.				X
4. CSHCN enters cases into a "registry" that will provide annual updates and ensure data to monitor continuity of care.		X		X
5. The registry provide a database of how many children have a hearing impairment in Nevada.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 12: FY05.

A 3/4 time contract employee was hired in January 2005 to continue the hearing screening program activities. The backlog of referrals is now clear and letters were sent to all those families whose infant was referred for further evaluation. The contractor has been meeting with hospital staff and audiologists involved with hearing screenig to identify problem areas in the program. Providers have continued to provide data on a monthly basis, and the data is then put into a SHD database to track cases. Only hospitals delivering more than 500 babies per year are required to provide hearing screening for newborns prior to discharge.

Infants who "fail" the initial Newborn Hearing Screening are referred to their PCP and to the E.I. clinics for further evaluation. Families needing financial assistance are referred into the CSHCN program, which can cover the costs associated with surgery and/or hearing aides if needed. The infants continue to be seen and evaluated by E.I. staff to assure that the child meets

appropriate developmental milestones. E.I. services transition the children into the school district special education program at 3 years of age, thus avoiding any break in service and assuring that the child achieves its maximum potential. This provided a "seamless" system of assistance to families.

Problems exist with gathering timely follow up data on infants referred for further evaluation. Families are not responding to the follow up letters, nor to a second follow up letter. Small numbers are being seen at the E.I. clinics. Private providers are refusing to provide any follow up data due to HIPAA concerns and are reluctant to commit to spending the time referring patients to the NBHS program.

Newborn Hearing program staff have met with staff working on the Real Choice Systems Change grant and the Needs Assessment team to share the results of the Newborn Hearing Screening needs assessment. Many of the issues identified will be addressed in the RCSC pilot projects and the RCSC grant will evaluate ways to improve the statewide infrastructure for the hearing impaired. The RCSC team worked with the Needs Assessment contractor and included data from the Newborn Hearing Screening needs assessment.

In calendar year 2004, the Newborn Hearing Screening program screened 96.4% of the infants born in facilities mandated to screen. The actual preliminary number of births in Nevada is 34,730 - but only 34,384 of those babies fall into the mandated category. Of these, 31,815 infants - or - 92.5% of infants born in Nevada received a hearing screen. An annual report was prepared in April 2004 and sent to the office of the Governor as required by NRS. A copy of the CY04 (prepared in the Spring of 2005) report to the Governor is attached.

c. Plan for the Coming Year

NPM # 12: FY06.

Plans are to continue to work with hospitals to enhance the quality and timeliness of data. Follow-back services will be enhanced to assure that all infants screened received appropriate follow-up treatment if indicated. Staff plan to contact all audiologists in the state to enlist their assistance in referring families to the NBHS program to at least provide "feedback" information regarding tiemly evaluation and treatment initiation. Staff will continue to work with hospital staff and individual providers to enhance data quality and timeliness, as well as develop standardized protocols and procedures for referral. Plans are to link with Medicaid and Nevada Check Up data to improve the capacity to assure effective treatment in a timely fashion.

Legislation in place mandates an annual report to the Governor. However, as the program continues and improves, not only data collection/reporting will improve, but additional analysis will be provided on follow-up, enrollment in E.I. etc. This data will be available for use by the Nevada Advisory Council on CSHCN to utilize in making recommendations for improvements in services to CSHCN. Plans are to meet with hospital staff to work on improvements in data collection and analysis that will produce not only improved information for state agencies, but also for individual hospitals.

The bill that established an Office of Disabilities in the DHR Director's Office also established a committee on Deaf and Hard of Hearing. The RCSC team and the Nevada Advisory Council on CSHCN will work with this committee. The RCSC team will link the Office of Disabilities - Deaf and Hard of Hearing committee with the Nevada Advisory Council on CSHCN relative to sharing data from the hearing needs assessment, transition issues and recommendations made as a result of the RCSC needs assessment.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	19	20	19	19	18
Annual Indicator	22.8	21.4	19.1	19.1	17.7
Numerator	122540	117118	112259	110568	105473
Denominator	536407	546068	587695	578890	595895
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	17	17	16	14

Notes - 2004

See explanation in NPM 13.a.

a. Last Year's Accomplishments

NPM # 13: FY 04. Percent of children without health insurance. FY 04: 18.6%

The most recent reliable estimate (January 2005) of the percent of Nevada children ages 0-18 without health insurance was 18.6%. The 18.6 percentage figure is a .5% decrease from the FY 03 figure of 19.1%. The estimated number of children from birth to age eighteen without health insurance (125, 856 in 2004) is based on an "Uninsured Persons in Nevada" study conducted by Decision Analytics in 2004 for Great Basin Primary Care Association (GBPCA). The number of children birth to eighteen used in the study was 677,189 (by the state demographer). Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System.

It is generally agreed that the most important reason for a decrease in the percent of children without health insurance was the significant increase in enrollment in Nevada Check Up. Nevada Check Up is the State Children's Health Insurance Program for children 0-18. Over half of uninsured Nevadans are working families and less than one-third of uninsured children in our state live below the federal poverty level. The Check Up program covers up to 200% of the federal poverty level. Nevada Check Up dramatically increased enrollment during the past three years to over 28,000 children. It is projected to go to 30,000 in the upcoming FY 06- FY 07 biennium. The Bureau worked closely with Nevada Check Up; a report on it is a standing agenda item for the Maternal and Child Health Advisory Board.

Major activities related to the decrease included improvement of the primary care safety net to promote access to care and public and private programs targeted to children. BFHS carried out a range of free public health programs and services which contributed to improving this performance measure by compensating for the lack of health insurance suffered by such a large number of children in the state. The Primary Care Development Center (PCDC)

represents the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. The primary care safety net is another means for mitigating the limitations to care related to lack of medical insurance for children. Other Bureau programs that promoted access to care included the MCH Campaign Information and Referral Line, which refers callers to Medicaid and Nevada Check up as well as other programs that might serve and refer them such as to pediatric care, WIC and CSHCN.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support expansion of the Nevada Check Up program to increase enrollment.		X		
2. Improvement of the primary care safety net to promote access to care by designating and recommending primary care, dental and mental health HPSAs, MUAs and MUPs and developing additional sites.				X
3. Promote referrals from public and private programs targeted to children; i.e. Early Intervention, WIC. the MCH Campaign, RCSC		X		
4. Updating of Nevada Uninsured Study every two years to assess need.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 13: FY05. Because of the gradual increase in enrollment in Nevada Check Up, it is generally agreed that the percentage of uninsured children has stabilized or decreased slightly. Nevada's percent of total uninsured persons remains consistently higher than the national average. National research and Nevada studies clearly demonstrate that uninsured children do not get the health care they need. This is particularly true for rural residents who are more likely to be uninsured and less likely to be offered coverage through employers. Uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services and immunizations, and are less likely to be seen by physicians when they are ill.

In FY 05 as in the preceding year, the Bureau carried out a range of free public health programs and services that offset the obstacles hindering access to care caused by lack of medical insurance. Uninsured children would be very unlikely to receive these kinds of services and benefits otherwise. The MCH Campaign is designed to reduce infant mortality and morbidity by establishing statewide systems of perinatal care to ensure that pregnant women have access to prenatal care regardless of ability to pay. The system also includes follow up of the infant to one year of age, by which age a medical home should be established. The Bureau's Child and Adolescent Health program promotes healthy behaviors among Nevada's youth through organized community efforts, public awareness campaigns, educational programs, and prevention activities. The CSHCN program provides a range of services that are coordinated, family-centered, community-based, and culturally competent. The Oral Health program provides preventive and health education services to children throughout the state. The purpose of the Women, Infants, and Children (WIC) program is to improve the nutritional health status of low-income women, infants, and children through nutrition education, vouchers

for supplemental foods, and referral to community resources including primary care resources. A new program, Real Choice Systems Change, seeks to enhance linkages and improve coordination of services for CSHCN. PCDC continued to represent the Bureau's main effort related to improvement of the primary care safety net to promote access to primary care. It is responsible for establishing Primary Care, Dental and Mental Health HPSAs, MUPs and MUAs as well as recommending J1-Visa physicians for underserved areas. The primary care safety net is another means for mitigating the limitations to care related to lack of medical insurance for children.

c. Plan for the Coming Year

NPM #13: FY 06. In the future, the Bureau will continue to carry out its ongoing activities outlined above, all of which serve to ameliorate the impact of lack of health insurance on Nevada's children. The Bureau will also continue to work closely with Nevada Check Up, which is expected to continue to increase enrollment. The Bureau, mainly through PCDC, will continue its work related to improvement of the primary care safety net to promote access to care. These efforts are targeted to the medically underserved, most of whom are uninsured or underinsured. The medically underserved are spread throughout Nevada's vast rural areas and in pockets of poverty in Nevada's two urban centers.

PCDC will also continue to support community development activities related to improvement of primary care resources available to medically underserved populations which, in turn, serves to offset the impact of lack of health insurance among children. Key partners for PCDC include Great Basin Primary Care Association, University of Nevada School of Medicine, Nevada Health Centers, Nevada Rural Hospital Partners, and the Office of Rural Health. These activities represent the leading efforts related to this measure and will continue to be the leading efforts next year.

The MCH Campaign IRL will continue to be a resource for referral to pediatric care as well as to Medicaid and Nevada Check UP.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	95	95	95	95
Annual Indicator	90	90	90	90	97.5
Numerator					95000
Denominator					97436
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	98	98	98	98	98

Notes - 2002

Medicaid is unable to estimate total eligible population in the State, 75,396 children 0 through 19 are enrolled in Medicaid.

Notes - 2003

Medicaid was unable to provide data regarding the number of potentially eligible who received a service paid by Medicaid.

They were able to indicate that 146,198 individuals under 20 years were eligible for an EPSDT exam, and that there were 109, 679 EPSDT sctreens completed. (There may be some duplication in this number due to the periodicity schedule).

a. Last Year's Accomplishments

NPM #14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. FY 04: 97.5%.

In Nevada, there is no "presumptive eligibility" available to families. Women and children are either "eligible" or "not eligible" for coverage under the Medicaid program. Persons who are "Pending" determination for Medicaid eligibility rarely are able to access services such as outpatient visits or pharmacy. The Medicaid eligibility is determined on a "month to month" basis, so providers are reluctant to chance providing services for which there may be no reimbursement available.

The Medicaid program was in the process throughout the year to set up a computer system that could be certified by CMS as a full MMIS system.

The SHD, including the Bureau, was in close contact with staff of Medicaid and Nevada Check Up throughout the year. The MCHAB continued to watch very closely Nevada's changing health care system and the implementation of Medicaid Managed Care and Nevada Check Up. The Chief of Medicaid Managed Care and Nevada Check Up of DHCFP provided regular updates to the MCHAB and ensured close collaboration of his staff with Bureau staff. The Bureau continued to look for ways to perform outreach for Medicaid and Nevada Check Up. Referrals to Medicaid and Nevada Check Up were made through the CSHCN Program, the MCH campaign and WIC. Bureau staff is able to check Medicaid and Nevada Check Up eligibility electronically, facilitating referrals and preventing duplication.

The State Medicaid Program was unable to provide data regarding the number of potentially eligible children. The Welfare Division was able to tell us that in Calendar year 2004, there was a total of 95,000 children ages 0-20 on the program. Medicaid can only provide data regarding the number of people that are eligible on a month-to-month basis. Medicaid does not track how many people actually used a service - but those individuals could have potentially used the service. Thus, to calculate the numerator - take the average of the month-to-month eligibles and use that as the numerator.

To determine the denominator - get the number of children ages 0-21 at the state demographer web-site. Use the 2000 Census Bureau report regarding the number of children in poverty (range is from 11%-15%). This data was rounded to 14% -then the number of children 0-21 was divided by 14% and used as the denominator.

As in prior years this is an estimate; with the new data linkages it should be possible to get better data for this measure in the future.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Bureau staff work with DHCFP regarding getting service related data.				X
2. Referrals to Medicaid are made by MCH Campaign - IRL, WIC, E.I. and CSHCN.		X		
3. The Bureau works with public & private providers to assure children access medical services.		X		
4. The Bureau works with DHCFP regarding getting data related to how many children have a medical home.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM 14. FY05.

Children in need of medical services, including those on Medicaid, access care through a variety of channels. Hospitals and community clinics continued to provide services on a "sliding scale", and then assist families to apply for Medicaid programs after the fact. The MCH campaign continued as a source of information and referral. The multi media component encourages families to seek a Medical Home for their children and provide public health education on the value of primary and preventive care. It also refers families to Medicaid for coverage of pediatric services.

The MCHAB continued to closely watch Nevada's changing health care system status and the implementation of Medicaid Managed care, particularly for dental services. The Chief of Medicaid Managed Care and Nevada Check Up of the DHCFP continue to provide regular updates to the MCHAB and with the MCH Chief ensures the close collaboration of his staff with Bureau staff. Referrals to Medicaid are made through the CSHCN Program, MCH campaign and WIC. (Bureau staff is able to check Medicaid eligibility electronically, facilitating referrals and preventing duplication.)

Despite a number of problems with "bugs" in the system, the Nevada Medicaid program recently received approval and certification of its newly developed MMIS system.

c. Plan for the Coming Year

NPM 14: FY06. Access to services by Medicaid and Nevada Check Up for eligible children will continue to be closely monitored by the Bureau, including PCDC, in FY06. The MCH Campaign will continue to be a source of information and referral. A campaign to encourage families to seek a Medical Home for their children will continue. The IRL will continue to refer callers with children, or expecting children, to Medicaid for coverage of prenatal and pediatric services.

The SHD, including the Bureau, will remain in close contact with staff of Medicaid and will collaborate on designing data collection tools. The MCHAB will continue to have Medicaid and Nevada Check Up access to services for eligible children as a standing agenda item. Staff of DHCFP and the Bureau will continue to work together to address unmet need.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1.2
Annual Indicator	1.3	1.0	1.3	1.3	1.3
Numerator	380	328	411	433	441
Denominator	30130	31297	32798	33605	35147
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1	1	1	1

a. Last Year's Accomplishments

NPM # 15: FY 04. The percentage of very low birth weight infants among all live births. FY 04: 1.2%

This measure is an infrastructure-building performance measure that is impacted by all births within the state. Data for this performance measure comes from State Vital Statistics, Center for Health Data and Research (CHDR).

In FY 04 (and into FY 05) most Women's, Infants and Children's (WIC) clinics throughout the state were transferred from state-run agencies to community-based organizations. Their clients are taught about healthy nutrition in pregnancy, in order to increase the likelihood of a healthy pregnancy outcome for both mother and baby. Close to half of the babies born in the State are WIC babies, born to WIC moms.

In May 2004, the MCH Prenatal Program, which paid for prenatal care, stopped accepting new applications from pregnant women for financial coverage of their pregnancy. The Bureau began a state-wide "Maternal and Child Health" campaign, which emphasizes the need for women to enter prenatal care in their first trimester and is a safety net for pregnant women who are not eligible for Medicaid or Nevada Check Up. One of the top goals of the campaign is to reduce the low birth weight rate. An information and referral line (1-800-429-2669) is available 24 hours a day where Nevadans may obtain information about services available for pregnant women in their community.

The Bureau contracted with Medicaid to promote the health and well-being of pregnant women and their infants. This statewide outreach campaign has been conducted through television and radio messages in both English and Spanish.

The Perinatal Substance Abuse Prevention (PSAP) program continued to collaborate with both public and private agencies on eliminating tobacco intake during pregnancy and postpartum. Senate Bill 307 from the 2003 Legislative session required all restaurants that serve liquor to prominently post a warning about drinking during pregnancy. The PSAP initiative has been working to ensure that knowledge of this law is known throughout the state. The PSAP program was awarded a grant by the Children's Trust Fund (CTF) to conduct a Fetal Alcohol Spectrum Disorders (FASD) public-education campaign in Nevada.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perform outreach and enroll qualified pregnant women into WIC.		X		
2. Provide obstetrical coverage for women through community based programs.		X		
3. Encourage early entry into prenatal care for all women in NV through the Maternal and Child Health campaign.			X	
4. Collaborate with Medicaid to educate pregnant women about pregnancy, nutrition, tobacco & drug abuse.		X		
5. Collaborate with MCHAB to educate public & providers on risks of having a low birth weight baby.		X		
6. Work with GBPCA members and other providers to develop additional sites for prenatal care.		X		
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 15: FY 05. The Bureau has continued expanding the Maternal and Child Health Campaign and collaboration with Medicaid. The Bureau sent out a "request for proposal" (RFP) to all agencies that may want to care for low-income pregnant women. One agency in Southern Nevada was awarded the contract for a pilot project. This project's scope of work is to specifically include social service referrals as needed and nutritional counseling for all clients. All clients must also be screening for domestic violence and perinatal depression. The pregnant women receive full obstetrical care, including antepartum, intrapartum and postpartum services. The infant is also followed for one year. In addition, in order to educate women about this and the need for early prenatal care, the Bureau is contracting with the Nevada Broadcaster's Association (NBA) to produce radio and television spots about this subject. The spots have been produced in both English and Spanish and are being broadcast statewide. Women are encouraged to call the MCH information and referral line at 1-800-429-2669. Information on a variety of topics pertinent to women and children may be obtained.

A contract with Medicaid is in place to educate the public about the importance of seeking early prenatal care, as well as the importance of nutrition and other factors during pregnancy. For each dollar spent on public education, Medicaid will match it. This allows the program to have a

greater impact statewide.

The Perinatal Substance Abuse Prevention (PSAP) campaign has been working with private and public agencies to educate the public about the dangers of tobacco, alcohol and drug use during pregnancy. Funding from a one-year grant is also allowing the Bureau to educate the public about the dangers of drinking during pregnancy through a bus advertisement campaign.

The Bureau is also collaborating with the Nevada Department of Corrections (NDOC) to educate incarcerated pregnant women about pregnancy, birth and infant care. A curriculum has been produced and the women will be encouraged to attend classes and use self-study modules to learn about pregnancy, postpartum issues, and infant health.

c. Plan for the Coming Year

NPM # 15: FY 06. Future plans to impact the low birth weight rate includes continuing the Maternal and Child Health Campaign and collaboration with Medicaid. Since the current contract for obstetrical services with the Southern Nevada vendor has been meeting the Bureau's goals, an additional "request for proposal" (RFP) was sent to all agencies that may want to care for low-income pregnant women. The best proposals have been selected. As anticipated vendors from both Southern Nevada and Northern Nevada were selected. The scope of work on the proposals is to specifically include social service referrals as needed and nutritional counseling for all clients. In addition, in order to educate women about the need for early prenatal care, the Bureau is in the process of contracting with RED, Inc. Communications to conduct a mass-media campaign in Southern Nevada. This campaign will include posters, bus advertisements and brochures in both English and Spanish. The campaign will include the MCH information and referral line (1-800-429-2669).

The Perinatal Substance Abuse Prevention (PSAP) campaign will continue working with private and public agencies to educate the public about the dangers of tobacco, alcohol and drug use during pregnancy.

Prenatal providers will continue to be kept abreast on perinatal issues, including folic acid consumption, nutritional information, HIV screening and treatment, immunizations during pregnancy and infections during pregnancy. The MCH Campaign will send the providers printed materials on these various topics, and the Bureau will collaborate with other agencies (such as Southern Nevada Area Health Education Centers) to distribute educational materials and offer classes to keep providers updated.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	9	8	7	6
Annual Indicator	11.0	6.6	6.6	13.2	11.5
Numerator	14	9	10	21	19

Denominator	127169	135560	150965	159580	165297
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	13	12	12	12

a. Last Year's Accomplishments

NPM #16: FY 04. The rate (per 100,000) of suicide deaths among youths aged 15 -- 19.
FY 04: 10.28

Data reported for this performance measure came from the CHDR, death certificates. This is preliminary data. This measure is an infrastructure building measure and affects children from age fifteen through nineteen.

The 2003 Youth Risk Behavior Survey (YRBS) reported 18% of Nevada's high school students have seriously considered suicide during the past 12 months. Fifteen percent planned how they would commit suicide and 9% actually attempted suicide.

New members were appointed to the Governor's Youth Advisory Council in 2004. The Council members selected suicide prevention as one of their top priorities. The members were educated about suicide prevention efforts in Nevada and planed on developing an action plan in 2005.

Collaboration continued with the Crisis Call Center of Northern Nevada. The Crisis Call Center received a subgrant from the Nevada State Health Division to provide youth suicide prevention presentations, statewide coalition building among county agencies and members, training efforts, and public awareness campaigns.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Governor's Youth Advisory Council continues to identify suicide prevention as a priority issue and develop an action plan to address this subject for FY 06.			**X**	
2. The GYAC will seek to work with the two new suicide specialists approved by the 2005 Legislature to be in the DHR Director's office to ensure youth issues are addressed.			**X**	
3. Injury prevention continues to track suicide in the Injury data base.				**X**
4. Injury Prevention continues to collaborate with the Crisis Call Center of Northern Nevada for 24/7 statewide phone coverage.			**X**	
5. Injury Prevention continues to apply for suicide prevention funding targeting youth.		**X**	**X**	

6. The PCDC designates mental health HPSAs, MUPS, and MUAs.				X
7. The Bureau participates with the Division of Child and Family Services' State Infrastructure Grant to improve mental health services for children and adolescents.				X
8. The Injury Prevention Program received a supplemental grant through the Centers for Disease Control and Prevention (CDC) for Violence Surveillance Integration and is currently integrating Violence Surveillance into the Core State Injury Surveillanc				X
9.				
10.				

b. Current Activities

NPM # 16: FY 05. The attempted and completed suicide rate in Nevada remains one of the worst in the nation.

The Bureau is continuing to participate and collaborate in the Suicide Prevention Statewide Study that is being conducted. In addition, the Division of Child and Family Services received a State Infrastructure Grant to address the mental health needs of children and adolescents. The Bureau is participating on a steering committee to help direct this infrastructure building effort and is serving on the evaluation committee for this grant.

Collaboration is also continuing with the Crisis Call Center of Northern Nevada. The Crisis Call Center has received a subgrant from the Nevada State Health Division to provide youth suicide prevention presentations, statewide coalition building among county agencies and members, training efforts, and public awareness campaigns. Their IRL is available 24/7.

The Governor's Youth Advisory Council continues to concentrate on suicide prevention as one of their top priorities. They appointed a suicide prevention subcommittee and are currently developing an action plan to address adolescent suicide prevention. They have been active in reviewing evidence based training and education programs as well as identifying organizations in their communities who are active in suicide prevention.

PCDC has continued to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

The Injury Prevention Program applied and received a non-competing supplemental grant through the Centers for Disease Control and Prevention (CDC) for Violence Surveillance Integration. This funding will require Nevada to integrate Violence Surveillance into the current Core State Injury Surveillance System. Violence Surveillance includes suicide mortality data and hospitalization for self-inflicted injuries data for the state. This data will be reported to the CDC.

c. Plan for the Coming Year

NPM 16: FY 06. The Data Surveillance of Suicides in Nevada will continue through 2005.

The Injury Prevention Program received a non-competing supplemental grant through the Centers for Disease Control and Prevention (CDC) for Violence Surveillance Integration. The Injury Prevention Program will be integrating Violence Surveillance into the Core State Injury Surveillance System. Violence Surveillance includes suicide mortality data and hospitalization for self-inflicted injuries data for the state. This data will be reported to the CDC.

PCDC will continue to work with GBPCA to promote sites where mental health services for adolescents can be obtained.

The Bureau will continue to work with the Division of Child and Family Services and the Division of Mental Health and Developmental Services to address the state's capacity to provide mental health services to children and adolescents through a system of care approach. In addition, a Statewide Suicide Prevention Coordinator will be hired by the Division of Mental Health and Developmental Services. Bureau staff will work closely with this Coordinator to ensure that the needs of MCH populations are addressed.

The Governor's Youth Advisory Council will actively implement their action plan that addresses suicide prevention for teens in Nevada.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	95	95	95	95
Annual Indicator	92.6	90.9	88.1	89.8	86.6
Numerator	352	298	362	388	382
Denominator	380	328	411	432	441
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments

NPM # 17: FY 04: Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates. FY 04: 89.3%:

The data for this measure has come from State vital statistics, CHDR.

This measure is an infrastructure building measure that impacts all low birthweight infants born in Nevada. Infants should be delivered at facilities that have appropriate care to match their needs.
Southern Nevada continues to grow rapidly. As a result, two new hospitals that provide labor, delivery and newborn services were opened. Statute changes of newborn and intensive care nurseries was completed in FY 04 to bring NICUs regulations into current standards and should make it easier for the various nurseries to work within their scope and will foster a better

working relationship between nurseries and neonatal intensive care units in the future.

The MCH Campaign encourages women to enter early prenatal care through its multi-media campaign and provides for obstetrical care through the Southern Nevada vendor. This vendor (University Medical Center) screens all clients for appropriateness of care, including domestic violence screening, nutrition, etc. The Bureau also has a contract with the Economic Opportunity Board (EOB) to provide prenatal care to underserved women and refer them to University Medical Center, which has a neonatal intensive care unit, for labor and delivery.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perform outreach and enroll qualified pregnant women into WIC, where they will receive referrals to needed services.		X		
2. Educate newly opened hospitals with newborn units about the revised NAC's regarding NICUs.		X		
3. Provide obstetrical coverage for women through community based providers.		X		
4. Promote early entry into prenatal care for all women in Nevada through the Maternal and Child Health Campaign.			X	
5. Collaborate with MCHAB to educate public and providers about risks of having low birth weight baby.		X		
6. Begin planning to hold a conference in the winter of 2006 for all interested whose subject is lifespan preparation for pregnancy.		X		
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 17: FY 05. The Maternal and Child Health Campaign has aired announcements on television and radio about the importance of entering early and continuous prenatal care. Proper nutrition and refraining from alcohol, tobacco and drugs has also been stressed to decrease the incidence of low-birth weight babies. The MCH information and referral line is also available to all women and families seeking information about a variety of topics, including where to obtain appropriate prenatal care. In addition, the agency contracted to provide obstetrical services to low-income, high-risk pregnant women is required to refer high-risk pregnant women to appropriate services, both medical and social. This will include referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery.

In FY 05 The MCH Campaign had a pilot project at a community based facility in Las Vegas to provide prenatal care to pregnant women with no insurance or other resource to pay for it. The Campaign is discussed in III B, Agency Capacity. This pilot project was very successful, exceeding the expectations for it.

A "Request for Proposal" was released in the Spring of 2005 and two agencies that provide obstetrical care have been selected for FY 06. Based on the quality of the proposals, there will be one vendor in the Southern Nevada area and one in Northern Nevada. One of the factors

considered when selecting the vendors was the availability of appropriate care for the newborn.

c. Plan for the Coming Year

NPM # 17: FY 06. The Maternal and Child Health Campaign will continue to conduct a mass-media, public education campaign about the importance of entering early and continuous prenatal care in order to reduce the low birth weight rate and infant death rate. The MCH information and referral line (1-800-429-2669) will be available to all women and families who may need information regarding neonatal care. In addition, the contracted community based obstetrical providers in Reno and Las Vegas established by a RFP in FY 05 will continue to be required to refer high-risk pregnant women to appropriate services, both medical and social. This will include referring women to physicians who deliver high-risk mothers at a facility with a Level III nursery.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	79	80	75	76	77
Annual Indicator	74.5	75.6	74.6	75.5	74.4
Numerator	22447	23645	24468	25362	26157
Denominator	30130	31297	32798	33605	35147
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

a. Last Year's Accomplishments

NPM #18: FY 04. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. FY04: 74.5 %

Data for this infrastructure building performance measure has come from State Vital Statistics and affects all newborns within the state. It is desired that all infants in Nevada be born to pregnant women receiving prenatal care beginning in the first trimester and continuing throughout the pregnancy.

Factors affecting Nevada's rate for early entry into prenatal care include its ongoing population growth and the growth of the Hispanic population in particular which historically does not enter into prenatal care until much later in the pregnancy.

Another factor that has affected the number of women who enter prenatal care in the first

trimester is the number of obstetrical physicians available. Due to a medical malpractice crisis, many physicians either stopped providing obstetrical services or moved out of state. Nevada has worked to encourage more obstetrical providers to practice in Nevada. To help attain this goal, the state legislature passed new legislation through a "special session" in 2002, which limits malpractice awards. In addition, the state developed it's own malpractice insurance pool which offers reduced rates to obstetrical providers. This has alleviated the physician shortage crisis to a degree, although most physicians' malpractice coverage through private carriers continues to be extremely high.

The Maternal and Child Health Campaign has also provided funding through a contract to a Southern Nevada provider to provide low-income, high-risk pregnant women obstetrical care. A contract with Medicaid has also led to a state-wide television and radio educational campaign that encourages pregnant women to seek early prenatal care. In addition, the MCH information and referral line, a toll-free, state-wide health line (1-800-429-2669) is available for women and families to call for information on where they may obtain low-cost prenatal care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct television and radio announcements in English and Spanish about the need for early prenatal care.			X	
2. Distribute brochures and other printed materials on the importance of early prenatal care at clinics and health fairs.			X	
3. Collaborate with providers to offer prenatal care to pregnant women regardless of ability to pay.		X		
4. Provide prenatal care to low-income pregnant women through contracted agencies		X		
5. Work with GBPCA to encourage FQHCs to include prenatal care in the services of their members.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NPM # 18: FY 05. The Maternal and Child Health campaign has been funding one obstetrical provider in Southern Nevada to provide services to low-income, high-risk pregnant women. This provider will serve at least 600 women during the year. Through the contract, the provider must attend health fairs and other functions to encourage women to seek early (first trimester) prenatal care. All of their services are available in English and Spanish.

The Bureau also contracts with the Economic Opportunity Board (EOB) of Clark County to provide obstetrical services to low income women, thus helping women who cannot afford prenatal care, and may not qualify for Medicaid, to obtain early and continuous prenatal care. The Washoe County District Health Department also receives Bureau assistance to provide care to high-risk women in Washoe County.

In addition, the Bureau has been contracting with the Nevada Broadcasters' Association to conduct a state-wide radio and television campaign that encourages pregnant women to obtain early and continuous prenatal care. All of the announcements are in English and Spanish. This campaign has been made possible through a contract with Medicaid, which matches 1:1 money spent on public education.

The Maternal and Child Health Line staff provide callers with information on where they can obtain prenatal care, and attend health fairs regularly throughout the state. This information and referral line is staffed by a bilingual (English and Spanish) person.

The Bureau has also released a "request for proposal" asking for proposals from obstetrical providers willing to serve low-income, high-risk pregnant women. Two vendors have been selected for FY06 -- FY09. Contracts with these vendors will ensure that pregnant women will gain early entrance into prenatal care.

c. Plan for the Coming Year

NPM #18: FY 06. Future plans include contracting with at least two obstetrical centers to provide full obstetrical services to low-income, high-risk pregnant women who are not eligible for Medicaid or Nevada Check Up. The Bureau sent out "Requests for Proposals" (RFP's) and choose the best proposals. One vendor will be from Southern Nevada and the other vendor will be from Northern Nevada. This replaces the contracts with EOB and Washoe County noted in FY 05.

The Bureau will also be conducting an educational campaign to make women aware of the need for early and continuous prenatal care. This will be a poster and bus billboard campaign in English and Spanish. The educational campaign is a result of collaboration with Medicaid. Medicaid matches all educational funding 1:1. To complement the educational campaign, the Bureau maintains a toll-free, statewide health line where women and families can access information regarding a variety of information, including where to obtain prenatal care and social/mental health services.

D. STATE PERFORMANCE MEASURES

State Performance Measure 11: *The percent of women of child-bearing age who receive screening and assistance for domestic violence should be increased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		22	15	18	10
Annual Indicator	NaN	7.9	8.1	7.4	7.7
Numerator	0	34727	38003	35814	38229
Denominator	0	442030	468635	484433	497955

Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	15	15	15

a. Last Year's Accomplishments

SPM # 11: FY 04. The percent of women of childbearing age who receive screening and assistance for domestic violence should be increased. FY 04: 7.6%

This data comes from the Nevada Network Against Domestic Violence and clinics the Bureau contracts with to provide obstetrical care for the numerator, and the denominator is from the State Vital Statistics, CHDR, using census data and data from the state demographer. All clinics contracted to provide MCH services must provide domestic violence screening.

This population based state performance measure is used to measure how many women have been screened and assisted for domestic violence. Increased assistance from the community and health care providers to women subject to intimate partner violence is needed in order to help all the women who are victims of this violence.

The Bureau, in collaboration with Vital Statistics, reviewed maternal deaths up to one year postpartum from all causes except accidents for the past twelve years. Suicide was the number one cause of death and homicide the second highest cause of death. Fifty-seven percent of the homicides were due to domestic violence. This information has been presented at the Rural Health Conference and the 1st Lady's Women's Health Conference in Nevada in the past year.

The Bureau's Maternal and Child Health Line, which can be accessed 24-hours a day, has a bilingual operator (English and Spanish) available and can refer callers to the line to appropriate domestic violence services in their community.

The Bureau has also been represented on the Nevada Attorney General's Domestic Violence Prevention Council, which oversees violence against women activities state-wide, including working with the police and court system. Through the Council, grants are given to various community organizations to help victims of domestic violence, conduct media campaigns about domestic violence prevention, and conduct activities within the school system to make children aware of domestic violence issues.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue promoting the statewide domestic violence health screening protocols.			**X**	
2. Collaborate with the Nevada Network Against Domestic Violence in conducting on-going training classes to health care providers.		**X**		
3. Collaborate with the medical and nursing schools to adopt and teach their students the statewide screening protocols.			**X**	
4. Collaborate with a variety of agencies to educate the public about domestic violence.			**X**	

5. MCH serves on the Nevada Attorney General's Domestic Violence Prevention Council.		X		
6. Conduct, in collaboration with other agencies, a five-year needs assessment of domestic violence issues.				X
7.				
8.				
9.				
10.				

b. Current Activities

SPM #11: FY 05. Current activities involve performing a statewide needs assessment to determine what the judicial, law-enforcement and advocate/shelter systems need to continue domestic violence prevention. Once the needs assessment is completed at the end of this fiscal year, the Attorney General's Domestic Violence Prevention Council and the Bureau will address the issues.

The Bureau has contracted with several agencies to provide prenatal and full obstetrical services to low-income, high-risk pregnant women. All women must be screened for domestic violence and referred to a variety of social service agencies if indicated.

The Bureau has also been collaborating with the Nevada Network Against Domestic Violence to continue the "health care standards" work. Presently, avenues are being explored to determine the best way to advance domestic violence screening into the medical and nursing schools throughout the state.
Bureau staff have presented information on domestic violence at conferences throughout the state.

c. Plan for the Coming Year

SPM # 11: FY 06:. This measure will continue into the next five year cycle.

The Bureau will continue to have the statewide, toll-free Maternal and Child Health Line available for callers needing referral to a social service agency in their area. In addition, staff will attend health fairs and conferences throughout the state to educate women and families about the availability of the line, and the services offered.

Collaboration with the Nevada Network Against Domestic Violence and the Attorney General's office will continue.

State Performance Measure 12: *Access to preventive oral services and dental care, regardless of ability to pay, should be increased for children, youth and women of childbearing age .*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance					

Objective		1.2	1.4	1.6	1.8
Annual Indicator		0.9	1.2	1.2	1.2
Numerator		899	1186	1290	1361
Denominator		986312	1013750	1047193	1160930
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.3	1.4	1.5	1.6

a. Last Year's Accomplishments

NPM 12: FY 04. Access to preventive oral services and dental care, regardless of ability to pay, should be increased for children, youth, and women of childbearing age. FY 04: 1.2

The numerator is the number of dentists with active Nevada licenses (1,361.) The denominator is the number of children, youth and women of childbearing age in the state (1,160,930). The numerator, number of dentists in the state, is from the State Board of Dental Examiners. The denominator is the sum of children, youth and women of childbearing age in the state (CHDR and state demographer). This measure relates directly to 2000 priority 10 relating to access to dental care as part of priority care, priority 9, reducing the incidence of early childhood caries, and priority 5, related to dental care for pregnant women.

In 2004, the SHD continued to partner with other organizations throughout the state to improve access to care. In FY 04 Health Access Washoe County (HAWC) Community Health Center opened a satellite dental clinic in Reno. Dental capacity at HAWC increased to 16 dental operatories and 4 full-time dentists.

HAWC also implemented a special project to provide dental services to pregnant women. This project was funded through a $50,000 grant the SHD received from HRSA. A second $50,000 grant from HRSA was used to fund a program to recruit volunteer dentists to provide services to uninsured children in Clark County. Access has also improved in rural communities. A community dental clinic opened in Yerington and the Miles for Smiles mobile dental program began provided services utilizing their mobile dental clinic to Elko, Lander, Humboldt, Eureka and White Pine Counties in Northeastern Nevada. Dental hygienists with Public Health Endorsement can provide almost the full scope of services they provide in a private practice setting under the authorization of a dentist in a public health setting without a dentist being present or authorization from a dentist.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with Medicaid staff to promote participation of local dental providers in Medicaid.		**X**		
2. Work closely with GBPCA to recruit dental providers interested in providing dental services to underserved communities and populations in the state.		**X**		

3. Provide technical assistance to all the Task Force for a Healthy Nevada Funded projects		X		
4. Assist dentists in locating underserved communities in which to practice.		X		
5. Work with the PCDC to place dentists in underserved areas.		X		
6. Continue to develop the oral health surveillance systems to guide program efforts.				X
7. Ensure access to dental care for the Medicaid and Nevada Check Up populations is a standing report for the Maternal and Child Health Advisory Board to facilitate their input into development of dental services for those populations			X	
8.				
9.				
10.				

b. Current Activities

SPM # 12: FY 05. The SHD continues to receive funding from the CDC to maintain and expand the Oral Health Program located in the Bureau of Family Health Services. The CDC Oral Health cooperative agreement funds activities that support the improvement of the oral health provider network to Nevada's most needy. There are a number of issues and activities the Oral Health Program is watching closely. One of them is the sunset of SB 133, a bill passed in the 2001 legislative session that established a number of dental licensure by credential options. SB 85 was introduced in this year's legislative session. It has been passed by the Legislature and signed by the Governor. It provides for the licensure by credential options created by the 2001 legislature through SB 133 would continue for an additional year. At that point, Nevada would then start to accept passage of the Western Regional Examining Board for licensure in Nevada.

The State Board of Dental Examiners is also in the process of passing regulations which if adopted, will allow a portion of the annual continuing education requirement for dentists and dental hygienists to be met by providing voluntary care through approved organizations and programs.

Finally, the Oral Health Program continues to support hygienists obtaining Public Health Endorsement.

c. Plan for the Coming Year

N.A.

State Performance Measure 14: *The rate of child abuse and neglect should be reduced.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance		95	4.4	4.2	4.0

Objective					
Annual Indicator		4.4	4.7	5.0	3.7
Numerator		2662	2875	3200	2468
Denominator		599079	617887	643516	662975
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.7	3.7	3.5	3.5	3.5

a. Last Year's Accomplishments

SPM #14. The rate of child abuse and neglect should be reduced. FY 04: 3.7%

Data for this performance measure numerator comes from the Division of Child and Family Services, and the denominator comes from State Vital Statistics, CHDR.

This is a population based state performance measure. Children should not be subject to abuse or neglect, and the Bureau has worked with the Division of Child and Family Services and the University of Nevada, Reno Cooperative Extension Agency to increase the awareness and screening of child abuse and neglect.

The Child Care Health Consultant trainer team has trained two classes of selected child care health consultants to become knowledgeable about the many components of quality in child care and the realities of various child care settings, including screening for child abuse. Bureau's MCH supported Perinatal Nurse Consultant is the SHD's member on this team.

The Bureau collaborated with the Junior Leagues of Nevada to produce and distribute a state-wide, multimedia campaign titled "Safe Haven". The Safe Haven campaign is designed to educate the public about a new Nevada law that allows parents to leave a baby (up to 30 days of age) at any "safe haven". Safe havens are hospitals, fire stations, law enforcement agencies, obstetric centers and independent licensed centers for emergency medical care. The law provides that the parent/s will not face criminal prosecution if they leave their baby at a designated safe haven.

P.A.N.D.A. continued in FY 04 to train providers who deal with children in recognizing child abuse in the craniofacial area.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Bureau will conduct training classes to child care health consultants on child abuse & reporting.		**X**		
2. The MCH program collaborates with agencies to educate the public about child abuse and reporting.		**X**		
3. Through the Early Childhood Comprehensive Systems grant, the Bureau will continue to train child care health consultants.				**X**
4. The Bureau has and will continue to give P.A.N.D.A. training to				

medical, dental and other providers.		X		
5. The Bureau will continue to promote the "Safe Haven" campaign for infants who might otherwise be abandoned in trash, toilets etc.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SPM #14: FY 05: "Safe Haven" materials were distributed to every "safe haven" facility in the state. This included all hospitals, urgent care facilities, fire stations and law enforcement agencies. Television and radio interviews were conducted and aired state-wide about the "Safe Haven" law and where parents could take their babies that were less than thirty days old if they were unable to care for them. As a result of these interviews, the Crisis Call Center received an increase in calls asking for more information.

The Bureau's Oral Health Program has been conducting "Prevent Abuse and Neglect through Dental Awareness" (P.A.N.D.A.) classes since bringing P.A.N.D.A. to Nevada in 2001. There has been a tremendous response to the program and we are continuing to provide classes. P.A.N.D.A. training also continues to be incorporated in the two dental hygiene schools in the state, as well as in the UNLV School of Dental Medicine, and the Pediatric Dental Residency in the UNLV School of Medicine.

The Bureau has been implementing the Early Childhood Comprehensive Systems grant. The activities of this grant include assessing for and planning what services all young children need to have a "seamless" system of care. Included in this system of care are child abuse and neglect services.

In addition, child care providers across the state are receiving the class "The Prevention of Illnesses in the Child Care Setting". In this class child care providers are taught how to look for injuries or illness in a child. If the injuries are suspected to be due to child abuse, they must report it to the authorities.

Bureau personnel have also been collaborating with the Division of Child and Family Services to prevent child deaths, including deaths due to abuse and neglect. A television and radio campaign in both English and Spanish has been developed, and will air for six months. It will be evaluated after that time in order to determine its effectiveness.

c. Plan for the Coming Year

N.A.

State Performance Measure 16: *Pregnancy among female adolescents ages 15-19 should be reduced.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective		6.0	6.0	5.8	5
Annual Indicator		5.6	5.0	4.8	4.8
Numerator		3663	3638	3720	3787
Denominator		65353	72773	76820	79608
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.5	4.3	4.2	4.2	4

a. Last Year's Accomplishments

SPM # 16. The rate of birth (per 1,000) for teenagers aged 15 through 19 years. FY04: 47.3 per 1,000 (preliminary)

The data for FY 04 is from state birth certificates, CHDR database. This measure is population based.

Nevada maintained a multi-faceted approach to teen pregnancy in FY 04. Abstinence funds were made available to community organizations at the end of FY04. Congress still had not re-authorized funding for abstinence education. Some community organizations have remained active using funds from other sources and the State continued to support them with technical assistance.

The Bureau and Southern Nevada Area Health Education Center (AHEC) collaborated on providing training for parents in the various issues of teen maturation and how to talk to their children. The curriculum used is Positive Choices, Positive Futures (PCPF)- Helping Parents Help Teens. AHEC has been successful in marketing the program and has reached a large number of Hispanic families.

The Governor's Youth Advisory Council (GYAC) continued to perform "Abstinence Works!" to 9-14 year old youth in Nevada. In FY04, over 600 of Nevada's youth viewed the program. The program was well received in Nevada's rural areas.

Additions were made to the Teen Pregnancy Prevention Resource Center, keeping it current. Materials in this Center were made available to community organizations and other interested parties upon request.

The contract between the State Health Division and the Nevada Broadcasters Association for the abstinence education media campaign continued until the end of FY04. The campaign consisted of radio and television non-sustaining commercial announcements. The radio NCSAs focused on parents of 9-14 year old youth and the television NCSAs were targeted to 9-14 year old youth themselves. The Nevada State Health Division supported the statewide media campaign by printing ads in local newspapers during teen pregnancy prevention month (May) that encouraged communication between adolescents and parents.

The Bureau worked with the Clark County Teen Pregnancy Prevention Coalition (CCTPPC) to further collaborative efforts to prevent teen pregnancies. Bureau staff attended CCTPPC meetings and provided technical assistance. They also assisted in the writing of the FY04

CCTPPC needs assessment. Along this vein of collaboration, Bureau staff also engaged local prevention coalitions in a dialogue about teen pregnancy and related risk and protective factors. Technical assistance was given to these coalitions around the issue of youth reproductive health.

The Bureau assumed the lead in a collaborative partnership to combined efforts around teen pregnancy prevention (TPP), sexually transmitted diseases (STD), and HIV. Bureau staff facilitated meetings and the process of writing a State action plan outlining how State programs could combine efforts in addressing the common risk and protective factors for TPP/STD/HIV prevention.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Governor's Youth Advisory Council's continues its commitment to teen pregnancy prevention via keeping TPP as one of their top priorities				
2. Support of community coalitions and organizations (including ones emphasizing minority populations) by making federal abstinence education funds available for subgrants for abstinence education and developing partnerships with the GYAC.			X	
3. Continuation of a statewide media campaign with Nevada Broadcasters Association promoting sexual abstinence		X		
4. Continue supporting workshops for parents of adolescents, teaching them the importance of healthy sexuality.		X		
5. Development and implementation of teen pregnancy prevention programs specifically targeting the Hispanic/Latino populations in Washoe and Clark Counties.		X		
6. Continue statewide teen pregnancy prevention presentations that target 9-14 year old students emphasizing the importance of abstinence.		X		
7. Continue maintenance of TPP webpage and resource center, Continue collaborating with other programs to promote the integration of teen pregnancy prevention with HIV and STD prevention efforts.			X	
8. Support teen health clinics in Washoe and Clark Counties.	X			
9. Support local school districts throughout Nevada, especially Clark County which is the fifth largest school district in the Nation.		X		
10. Maintain TPP webpage and resource center			X	

b. Current Activities

SPM # 16: FY05. The main activities for Nevada's teen pregnancy prevention initiative include community involvement through community organizations, the Nevada Statewide Coalition Partnership, which is a network of prevention coalitions located in ten of Nevada's seventeen counties, workshops for parents of adolescents, and the continuation of the GYAC, which has identified teen pregnancy prevention as one of its top three priorities.

The majority of Nevada's abstinence education funds have been made available to the community organizations through subgrants via an RFP process. These funds are targeted towards the Hispanic/Latino populations of Clark and Washoe counties which are the state's

most populous counties with the highest rates of teen births.

Some funds are also being used to promote parental communication and connectedness throughout the State. Two subgrants provide education for parents in the various issues of teen maturation and how to talk to their children about abstinence. Positive Choices, Positive Futures is a popular program in Southern Nevada as the Southern Area Health Education Center has been successful in marketing it. An attempt to replicate the program in Northern Nevada is currently being explored.

Materials in the Teen Pregnancy Prevention Resource Center are available to community organizations and other interested parties upon request. The State Health Division maintains the State Teen Pregnancy Prevention website: http://health2k.state.nv.us/CAH/teenpregprevention.htm, which offers resources to the public.

Bureau staff continues to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth. Currently an initiative to combine efforts to prevent STDs, HIV and teen pregnancy by addressing common risk factors as well as promoting protective factors continues. This initiative is a collaboration between the State Department of Education, the State Division of Mental Health and Developmental Services, the State Division of Child and Family Services, the State Welfare Division, and the State Health Division's Bureau of Family Health Services, Bureau of Community Health, and Bureau of Alcohol and Drug Abuse. The name of the collective group is the Nevada Stakeholders for the Reduction of Adolescent Risk Behaviors.

The media campaign with Nevada Broadcasters Association will be starting again in late FY 05 as a new contract is currently in the approval process.

The Governor's Youth Advisory Council (GYAC) continues their "Abstinence Works!" presentations on a limited basis. The GYAC is currently evaluating the program in order to decide if they will continue it with revisions, which include a stringent evaluation component, or pursue the use of another abstinence curriculum for in school use.

c. Plan for the Coming Year

N.A. This measure is being replaced with a performance measure to reduce teen birth rates in Hispanic/Latino youth as this population has a disproportionately high birth rate. The preliminary birth rate for Hispanics (15-19) in FY 2004 was 49.8 per 1,000.

State Performance Measure 17: *Access to specialty and subspecialty services available to CSHCN should be increased.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		155	75	82	80
Annual Indicator		65.4	82.0	68.0	62.5

Numerator		508	573	579	420
Denominator		7769	6989	8519	6724
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	70	75	75	75

Notes - 2004

The CSHCN program funds specialty clinics for cranio-facial abnormalities, genetics, and for metabolic disorders - thus assuring the availability of these services for CSHCN. These clinics are held at the Early Intervention clinic sites and are the "countable number".

Due to the lower CSHCN caseload (attributed to the success of getting families into the Medicaid and SCHIP programs) the "countable number" is lower. Currently, there is no way to track any additional speciality services through the Medicaid and SCHIP programs.

a. Last Year's Accomplishments

SPM #17: FY04: FY 04: Access to specialty and subspecialty services available to CSHCN should be increased. FY 04: 86.9/1,000.

The data source for this measure is the CHDR vital statistics, PCDC's State Physician's Survey, and the Bureau's physician database. This measure is related to Year 2000 priority 7, access of CHSCN to specialty and subspecialty care.

Historically, in Nevada, the CSHCN Program was the primary source of specialists and subspecialists for children. Providers, state agencies and advocacy organizations referred and collaborated with the program to serve children. For many years, there were a limited number of specialists and subspecialists in the state. This was primarily due to the relatively small population of the urban areas and the sparse population of the rural areas.

Physicians in Nevada frequently referred to specialists out of state in order to access the specific services needed by a patient. Families needed to travel long distances to ensure that their child received appropriate services, and the CSHCN Program provided assistance in a variety of ways including information and referral to Medicaid, county assistance programs, insurance advocacy, assistance finding travel support, referral to specialty clinics, payment for services, and linkage with volunteer organizations. Follow up services locally was often a problem and families were forced to travel long distances. The CSHCN Program sponsored specialty clinics during that time for such specialties as cleft/craniofacial, orthopedic, metabolics, and genetics to assure that families had local access to specialists. CSHCN contracted with specialists from out of state to come to Nevada and provide clinical consultation.

E.I. Clinics offering multi-disciplinary evaluations, referred to the CSHCN Program and to specialty clinics when indicated, thus assuring that children already identified as CSHCN receive appropriate services. Specialty clinics served a total of 526 CSHCN. The State Newborn Screening and Newborn Hearing Screening programs refer to the CSHCN Program and specialty clinics as well, thus building a more "seamless" system of services for families and services providers of CSHCN.

In FY04, there were 579 specialists serving 6,663 CSHCN, of which only 72 were pediatric specialists. This is an increase in the number of specialists serving CSHCN.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN staff will continue to work with families and providers to ensure access to appropriate specialty services.		X		
2. CSHCN will continue contracts with specialists so children will continue to have needed services available locally.		X		
3. CSHCN staff will continue to work with families to assist with the eligibility process for Medicaid, Nevada Check Up, County programs, and community organizations, as well as provide advocacy services with private insurance carriers to assure service		X		
4. CSHCN staff will provide information and/or training for E.I Bureau staff to support a collaborative relationship, and provide referral information as needed.		X		
5. CSHCN pays for treatment for eligible children.		X		
6. CSHCN staff works with Medicaid to identify CSHCN in HMOs for coverage under fee-for-service.		X		X
7. CSHCN staff provide advocacy services with private insurance carriers to assure coverage for CSHCN.		X		
8.				
9.				
10.				

b. Current Activities

SPM # 17: FY05. The CSHCN Program continued to provide specialty clinic services to children Statewide. The services span a wide scope of specialties including Cranio-facial, Metabolic, and Genetics. Children needing other types of services are referred to providers in the local private sector who have agreed to accept CSHCN program coverage. Children eligible for Medicaid and Nevada Check Up are also seen by this same group of providers. CSHCN staff continued to provide advocacy for families during the eligibility process for both the Medicaid and Nevada Check Up programs.

Despite the national healthcare crisis regarding physician liability issues, those providers seeing CSHCN have continued to provide services to clients. CSHCN staff work with providers to clarify program coverage, reimbursement and claims resolution in order to maintain a healthy "working relationship" with each provider and their office staff. Families are advised of program coverage and limitations as well, thus providing an improved atmosphere of trust between provider and patient. Staff advocate with private insurers for coverage of specific services that may be a "bit out of the ordinary", but directly related to a diagnosis that may be very rare. CSHCN staff provide information to insurers regarding the diagnosis, and also provide literature to providers unfamiliar with a specific disorder. The CSHCN program authorizes office visits with sub-specialists if necessary to clarify the causes, symptoms and treatment that will be necessary in some rare disorders within this population. These activities have been successful in promoting an ongoing working relationship with providers and families in keeping specialty services accessible. Providers, and families, call the CSHCN Program to access information relative to assisting with contacting consultants, assistive devices, hearing aides, eligibility for Medicaid/Nevada Check Up, and advocacy with private insurance.

CSHCN caseload dropped primarily due to the expanded eligibility of Medicaid and Nevada

Check Up. Staff attended multiple health fairs around the state to provide information and referral to families and various community agencies. Staff met with the Department of Education to work on developing pilot projects to improve the status of nutrtion services for special needs children.

c. Plan for the Coming Year

N.A.

State Performance Measure 18: *Increase access to enabling services that assist CSHCN in care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada Check Up, and/or purchase of health insurance .*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		590	600	550	575
Annual Indicator		583.9	501.2	542.9	187.5
Numerator		4536	3503	4625	2224
Denominator		7769	6989	8519	11864
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	190	195	200	200	200

Notes - 2004

The CSHCN program has been successful in assisting families to become eligible for Medicaid and Nevada Check Up (Title XXI), thus the CSHCN active caseload has decreased. In Nevada, the active CSHCN case becomes "closed" when the child becomes eligible for the Medicaid or Check Up programs. There is no way of determining exactly how many CSHCN are receiving services under Medicaid or Nevada Check Up, as those programs are unable to provide data specific to CSHCN. In addition, staff is working with Real Choice Systems Change grant and Family Ties/Voices staff to develop increased community support services, local access to information and referral, web-site access, and provide advocacy services to enhance the availability of respite, transportaion and mental health services.

a. Last Year's Accomplishments

SPM # 18: FY04. Increase access to enabling services that assist CSHCN in care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada Check Up, and/or purchase of health insurance. FY 04:

Data for this measure is from the CHDR's vital statistics, BFHS caseload, SCC's Medicaid and Nevada Check Up, and the state demographer. This measure is related to Year 2000 priority 7,

access to specialty and sub-specialty care, and priority 8, access to quality day care.

CSHCN in Nevada received care coordination services through the CSHCN Program and the E.I. clinics in Las Vegas and Reno. E.I. services provided multi-disciplinary diagnostic evaluations and made recommendations and referrals for extended physician, physical, occupational, and speech therapies, as well as for a variety of mental health and developmental services. CSHCN referred from other sources were advised of the availability of specialty clinics supported by CSHCN. Many of the children received extended treatment at the clinics, while receiving ongoing evaluation of their progress. In those cases of children needing more services, staff determined eligibility and assisted families in accessing Medicaid, Nevada Check Up, Shriner's, and other community and advocacy organizations.

The CSHCN Program provided care coordination to all children eligible for the program. Medical services being requested are reviewed for program eligibility and appropriateness. Only services provided by "qualified" providers are approved, thus ensuring quality service delivery. Staff worked with providers to ensure that the children receive needed care and that PCPs provide ongoing follow up evaluation and treatment. Staff also provide information, referral and advocacy for all those referred, even those not directly eligible for program coverage. Staff maintained a provider list of specialists and subspecialists who work with CSHCN, as well as lists of equipment suppliers, community organizations, advocacy groups and volunteer groups that assist families of CSHCN. Families received assistance in "navigating the system" regarding Medicaid and Nevada Check Up eligibility and advocacy information pertaining to private insurance coverage.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program continues efforts to provide up to date information for families relative to community resources available, and will provide information and assistance to PCP's trying to access services for patients.		X		
2. Staff continue to work with Medicaid and Nevada Check Up staff to better identify CSHCN within their programs, to ensure that children receive needed medical services, and to clarify conditions needing specialty services.		X		
3. CSHCN provides Medicaid, Nevada Check Up and private insurers input into criteria for coverage of specific conditions to ensure that all children, especially CSHCN, receive quality and appropriate medical care.		X		
4. CSHCN staff works with parent groups to assure children transition into the special education programs within school districts, and will enhance this collaboration to assisting parents improve transitions and enhanced college/vocational training pla		X		
5. CSHCN/RCSC works with the Nevada Advisory Council on CSHCN to ensure council involvement during and after the pilot project period and activities.			X	
6.				
7.				
8.				
9.				

10.					

b. Current Activities

SPM #18: FY05. The CSHCN Program continues to provide care coordination and enabling services to families. Staff assist families with the eligibility process for other programs such as Medicaid and Nevada Check Up, and provided advocacy for families with private insurance. They also work with the families and insurance to clarify the children's conditions and the recommended treatment, thus ensuring that CSHCN receive timely and appropriate services for "unusual" conditions.

Families in need of assistance with travel, lodging, respite, and mental health services receive information and referral as to how to access these services in the community. CSHCN needing "specialty" services are referred to the specialty clinics supported by the CSHCN Program or are referred to specialists in the area who are CSHSN providers. CSHCN staff also worked with Shriner's in providing ancillary services, and ensuring specialty follow-up care and with the PCP in Nevada. To ensure that families have a community contact, referrals from out of state are linked with local community health nurses. CSHCN provide families with linkages to community organizations, parent advocacy groups such as Family Ties and E.I. clinics, which have support groups in place.

The Department of Human Resources was awarded a Real Choice Systems Change (RCSC) grant that provides support for the development of a needs assessment to more clearly define areas of service and location that are in need of improvement regarding CSHCN services in Nevada. This grant has been placed in the Bureau as part of its CSHCN program. The RCSC project contracted with a vendor to perform a statewide CSHCN needs assessment. They have also developed a Nevada Advisory Council on CSHCN that has been given decision making responsiblity in the direction and content of RCSC pilot project activities. They have held four meetings in FY 05.

c. Plan for the Coming Year

N.A.

State Performance Measure 19: *Homes for primary medical care, regardless of ability to pay, should be increased for children, youth , women of child bearing age and CSHCN ages 0-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		2	4	4	25
Annual Indicator		1.9	2.2	2.1	2.3
Numerator		1559	1768	1768	1970
Denominator		828940	820710	854021	851978
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.7	3	3	3.1

Notes - 2004

The Annual Performance Objective for this NPM # 19 2004 should be 2.5, not 25. The system is not letting this correction be made.

a. Last Year's Accomplishments

SPM # 19. FY 04: Homes for primary medical care, regardless of ability to pay, should be increased to children, youth, women of child bearing age and CSHCN ages 0-19. FY 04: 2.3

This figure is up from 2.1 in FY 03. Homes for primary medical care are interpreted to include persons who are covered by medical insurance. The most recent reliable estimate (January 2005) of Nevada children and youth including CHSCN age 0-19 without health insurance was 18.5% in 2004. The 18.5 percentage figure is a decrease from the FY 03 total of 19.0%. The number of children age 0-19 without health insurance (130,783) was based on an "Uninsured Persons in Nevada" study conducted for Great Basin Primary Care Association in 2004. The total number of children 0-19 (707,791) was the estimate used in the "Uninsured Study." The estimated percent of women of childbearing age (15-44) without health insurance (92,670) in 2004 was 21.5%. The total number of women 15-44 (430,367) was also the estimate used in the "Uninsured Study". This measure related to Year 2000 priority 10 for 2004, access to primary care.

The basis for this measure was the 2004 ratio of primary care providers available in Nevada to the number of women of childbearing age, children and youth including CSHCN ages 0-19 in the state who had a medical home. The ratio was 1,970 primary care providers to 851,978 target population with a medical home, equivalent to the number of insured within those categories.

Efforts to improve this measure are related to Infrastructure Services in terms of the Performance Measurement System. SPM 19 overlaps National Performance Measure (NPM) # 13. The most important efforts in FY 04 related to this measure involved four major ongoing activities:
1. Substantial increase in enrollment in the Nevada Check Up program.
2. Public and private programs targeted to women and children; i.e. Early Intervention Services, WIC.
3. Improvement of the primary care safety net to promote access to care, particularly for the uninsured.
4. The MCH Campaign discussed in Section III B, State Overview.

Ongoing activities through the Bureau's Primary Care Development Center (see NPM 13) continued to contribute to improvement of the primary care safety net, which helped to increase access to and the availability of primary care providers throughout the state, most noticeably in medically underserved areas. PCDC activities included designating health professional shortage areas, placing NHSC and SEARCH providers in underserved areas, providing financial and technical support for community development activities related to primary care. Key partners for PCDC include Great Basin Primary Care Association, University of Nevada School of Medicine, Nevada Health Centers, Nevada Rural Hospital Partners, and the Office of Rural Health.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support expansion of the Nevada Check Up to increase enrollment for children			X	
2. Improvement of the primary care safety net to promote access to care, particularly for the uninsured through the designation of HPSAs, MUPs, and MUPs, and financial and technical support for community development activities related to primary care.		X		X
3. Support public and private programs targeted to women and children that refer to Medicaid and Nevada Check up including WIC, CHSCN, MCH Campaign and Early Intervention.		X		
4. Technical support for community development activities related to primary care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SPM # 19: FY 05. Nevada Check Up increased enrollment during FY 05 from 27,006 in April 2004 to 28,028 in April 2005. Regarding primary care physicians (PCPs), it appears that the increase of new PCPs in FY 04 offsets the increase in the population of the target groups.

All of the BFHS programs and services that contributed to SPM 19 in FY 04 continued to be carried out in FY 05. BFHS activities targeted to women and children that contributed to this performance measure included CHSCN, the MCH Campaign and WIC, and Early Intervention Services in BEIS. The contribution of public and private programs targeted to women and children was also discussed in the NPM section concerning NPM 13.

Ongoing activities through PCDC (see NPM # 13) continued to promote improvement of the primary care safety net, which served to increase access to and the availability of primary care providers throughout the state, most noticeably in medically underserved communities. PCDC continued to provide financial and technical support for community development activities related to primary care such as the Washoe County Access to Healthcare Network and the Clark County Health Access Consortium.

c. Plan for the Coming Year

N.A.

State Performance Measure 20: *Access to mental health services regardless of ability to pay for children, youth, women of child bearing age, and CSHCN, should be increased.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		3	3.5	4	3
Annual Indicator		1.9	2.0	1.9	1.5
Numerator		1559	1653	1556	1702
Denominator		828940	820710	827289	1160930
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2	3	4	5	5

Notes - 2004

Estimate as data is not available for this year but no change from 2003 is expected as no additional resources were made available.

a. Last Year's Accomplishments

SPM # 20. The percent of children and youth ages birth to 21, women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased. FY 04: 1.5.
BFHS continued to carry out a range of activities which directly and indirectly benefited the target populations for this measure in relation to improving access to mental health services.

The Division of Child and Family Services undertook the establishment of neighborhood centers in Clark County with mental health, community outreach, and early intervention coordinators. These neighborhood centers utilized a system of care and wrap around approach. The Bureau of Early Intervention Services (BEIS) moved to the Health Division in FY 04. BEIS clinics are located in the Neighborhood Centers. Early Intervention services were co-located with mental health services in Las Vegas and within close proximity in Reno.

In FY 04 PCDC re-designated six entire rural counties as mental Health HPSAs. PCDC placed one foreign medical graduate J-1 Visa psychiatrist in a State clinic in Las Vegas.
PCDC also helped to place two psychologists and four social workers in medically underserved areas through the National Health Service Corps. PCDC's Quentin Burdick program continued to carry out health-related projects in four Elko County communities.

The Child and Adolescent Health program included mental health in all of its efforts. A state-wide team was assembled by the Early Childhood Comprehensive Systems program. One of the components of this program includes addressing the social and emotional needs of children and their families. The Child and Adolescent Health program also established a working group to address teen pregnancy, HIV disease, and sexually transmitted diseases. This workgroup included members from the Division of Child and Family Services who is responsible for mental health programs for children and adolescents in Reno and Las Vegas and the Division of Mental Health and Developmental Services who is responsible for children's mental health in the rural counties in Nevada.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PCDC will continue to designate Mental Health HPSAs, MUPs and MUAs.		X		X
2. Early Intervention services will stay co-located with mental health services in Las Vegas and across the parking lot in Reno.		X		
3. The Child and Adolescent Coordinator is working with MH/DS to solicit funding for mental health services for Nevadans including the MCH Populations.		X		
4. ECCS is addressing access to mental health services as part of the statewide plan.				X
5.				
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10.				

b. Current Activities

SPM # 20: FY 05:

PCDC continues to designate Mental Health HPSAs, MUPs and MUAs throughout the State and help to place mental health professionals in medically underserved communities through the J-1 Visa Waiver program and the National Health Service Corps.

The Child and Adolescent program continues to explore ways to include mental health in all initiatives and increase access to services. The Early Childhood Comprehensive Systems program will continue to develop a statewide plan, including activities to address access to mental health services by children and their families.

The Child and Adolescent Health Program's efforts to address teen pregnancy prevention, HIV, and STD's have progressed into the formation of the Nevada Stakeholders to Reduce Adolescent Risk Behaviors. This group, which includes members for the mental health service delivery system, has been working on an action plan to address adolescent risk behaviors, including social and emotional issues.

A state-wide suicide prevention coalition was initiated in FY 05. Bureau staff is actively involved in this coalition and continue to collaborate with community partners on ways to improve Nevada's ability to prevent suicide amongst the MCH populations.

The Division of Child and Family Services applied for and was awarded a State Infrastructure Grant (SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address child and adolescent mental health and substance abuse issues. The Child and Adolescent Health Program is actively involved in this program and serves on the grant's evaluation subcommittee.

Bureau staff participated in a Behavioral Health Redesign project for the Medicaid program in Nevada. The results of the redesign went before the Nevada Legislature as part of the DHCFP

budget. It was adopted; the redesign will result in the increased ability for licensed clinical social workers (LCSW) and marriage and family therapists (MFT) to obtain reimbursement from Medicaid for counseling services. It provides for specialty clinics covered by Medicaid for behavioral health staffed by LCSWs and MFTs.

The Perinatal program requires all contracted providers of Obstetrical services to conduct a screening for postpartum depression as well as follow-up treatment and/or referral. The Perinatal program also works with the Clark County Health District to provide information and referral to families who experience Sudden Infant Death Syndrome.

c. Plan for the Coming Year

N.A.

E. OTHER PROGRAM ACTIVITIES

As noted in III, E, State Agency Coordination, Early Intervention is now in the Bureau of Early Intervention Services (BEIS) in the SHD. Title V MCH Block Grant funds support these services. BEIS is collocated with the Bureau.

The Nevada WIC program piloted an Electronic Benefit Transfer (EBT) system for the provision of WIC benefits to participants in Washoe County starting in 2002. Nevada is now rolling out of WIC EBT in Las Vegas; EBT in Las Vegas should be accomplished by the end of 2005. The EBT card is a "smart" card which can ultimately contain other data such as a child's immunization record or participation in Head Start. With EBT participants can go to any WIC vendor who has EBT capability for their groceries, and only have to take what they need at the time. Vendors do not have to worry about out of compliance purchases that lead to vendor fines, as foods are accepted or rejected electronically and do not rely on the grocery clerk's knowledge of WIC. Vendors are reimbursed for the WIC purchases over night, in contrast to taking several weeks with paper vouchers.

All activities of Nevada MCH are included one way or the other in performance measures and are recorded within the National and State Performance Measures Sections. If they are not included, they are not addressed by Nevada MCH. This includes purchase of health insurance, and applied research, all listed in the Pyramid. As previously noted, WIC is part of MCH.

Nevada's has three toll-free hot-lines. The first and primary line is the MCH Campaign's 1-800-429-2669. In CY 2004 when it was new it had 1,183 calls. The second line is part of a WIC/Immunizations/Medicaid promotion. Its number is 1-800-8 NEV WIC. It is discussed under NPM 7. The third line started in FY 05 as the CSHCN line and is now being widely marketed as such. it is 1-866-254-3964.

All three lines are widely marketed. They are all answered in the Bureau and are all bilingual, both English and Spanish. They are included in multi-media bilingual campaigns for the MCH Campaign, CSHCN and WIC. They will all be a part of the new 211 system approved by the 2005 Legislature in June 2005.

F. TECHNICAL ASSISTANCE

Nevada's priority for this year once again is technical assistance on dealing with health disparities. The disparity in African American birth outcomes in particular is alarming. Linking to successful initiatives that address health disparities would be very helpful. In FY 05 Clark County unsuccessfully applied for a Healthy Start Grant to address birth outcome disparities in African Americans. This is the third year assistance of this nature has been requested.

Nevada's cultural competency training for Bureau staff and others who work with MCH is a priority left over from prior years. Such training should be a follow-up to the training offered in 1999 through the National Center for Cultural Competency that was not very well received by staff. The Bureau has identified a Local source for the training at the University of Nevada Reno and is only awaiting word that technical assistance funds are available. In 2005 the Bureau is still awaiting word.

V. BUDGET NARRATIVE

A. EXPENDITURES

Form 3, State MCH Funding Profile shows FY 2004 MCH expenditures amounted to $1,614,364 with the appropriate expenditure match of state funds adhering to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The State expenditure amount was $1,210,773 for a total of $2,825,137. The MCH budget for FY 2004 was $3,921,016, so expenditures were $1,095,879 less than budget, or 27.9% of the budgeted amount. The expenditure variance is almost entirely explained by the fact the budgeted amount far exceeded the actual grant amount awarded.
Other federal funds expended during FY 2004 amounted to $39,157,753. This compares with the budgeted amount of $37,225,573 to exceed budgeted expenditures by 5.2%. For FY 2004 the total budget under the guidance of the MCH Chief was $41,146,589 and expenditures under the guidance of the MCH Chief amounted to $41,982,890, which exceeded budget by $836,301, or 2.0%.

Form 4, Budget Details By Types of Individuals Served provides the detail for budget expenditure variances by population served. Pregnant Women included budgeted expenditures of $1,235,176 and actual expenditures amounted to $1,148,043 in FY 04. The budget expenditure variance for Pregnant Women is $87,133, or 7.1% below the amount budgeted. Expenditures for the Pregnant Women population included newborn screening expenditures. Federal expenditures for Pregnant Women amounted to $271,106, or 16.8% of federal funds expended in FY 2004.

Form 4 for FY 2004 for Children 1 to 22 years old included budgeted expenditures of $1,235,177 and actual expenditures amounted to $722,686. The budget variance for this group is a decrease of $512,491, or 41.5% below the amount budgeted. This decrease is explained by the budgeting methods used for FY 2004 that straight-lined budgeted expenditures at 30% for each population group and the 10% maximum allowance for administrative expenditures. Federal expenditures for Children 1 to 22 years old amounted to $539,686, or 33.4% of federal funds expended in FY 2004.

Form 4 for FY 2004 for Children with Special Health Care Needs included budgeted expenditures of $1,235,177 and actual expenditures amounted to $758,694. The budget variance for this group is a decrease of $476,483, or 38.6% below the amount budgeted. This decrease is explained by the budgeting methods used for FY 2004 that straight-lined budgeted expenditures at 30% for each population group and the 10% maximum allowance for administrative expenditures. Federal expenditures for Children with Special Health Care Needs amounted to $607,858, or 37.7% of federal funds expended in FY 2004.

Form 4 for FY 2004 for Administrative costs, included budgeted expenditures of $215,486 and actual expenditures amounted to $195,714. The budget variance for this group is a decrease of $19,772, or 9.2% below the amount budgeted. This decrease is explained by the fact the amount budgeted exceeded the amount awarded and provided an excessive budgeted amount for administrative expenditures. The $195,714 was less than the 10% threshold for Administrative expenditures per grant guidance.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Direct Health Care Services for FY 2004 included budgeted expenditures of $1,686,037 and actual expenditures amounted to $1,170,545. The budget variance for this group is a decrease of $515,492, or 30.6% below the amount budgeted. This decrease is partially explained by the total budget being based on a grant award of $2,154,866 that far exceeded the actual amounts available for the budget period. Federal expenditures for Direct Health Care Services amounted to $574,235, or 35.6% of federal funds expended in FY 2004.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Enabling Services for FY 2004 included budgeted expenditures of $744,993 and actual expenditures amounted to $572,943. The budget variance for this group is a decrease of $172,050, or 23.1% below the amount budgeted. This decrease is explained by the total budget being based on a grant award of $2,154,866 that far exceeded the actual amounts available for the budget period. Federal expenditures for Enabling

Services amounted to $481,443, or 29.8% of federal funds expended in FY 2004.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Population-Based Services for FY 2004 included budgeted expenditures of $1,097,884 and actual expenditures amounted to $756,522. The budget variance for this group is a decrease of $341,362, or 31.1% below the amount budgeted. This decrease is explained by the total budget being based on a grant award of $2,154,866 that far exceeded the actual amounts available for the budget period. Federal expenditures for Population-Based Services amounted to $233,560, or 14.5% of federal funds expended in FY 2004.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Infrastructure Building Services for FY 2004 included budgeted expenditures of $392,102 and actual expenditures amounted to $325,127. The budget variance for this group is a decrease of $66,975, or 17.1% below the amount budgeted. This decrease is explained by the total budget being based on a grant award of $2,154,866 that far exceeded the actual amounts available for the budget period. Federal expenditures for Infrastructure Building Services amounted to $325,127, or 20.1% of federal funds expended in FY 2004.

B. BUDGET

This FY 2006 MCH application budget adheres to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget planning purposes at $2,126,405 and is based upon $1,976,405 in FY 06 allocation and an anticipated carryover of $150,000 from the FY 05 allocation. The state MCH match, budgeted at $1,482,304 is comprised of State General Fund dollars and fees generated by the Newborn Screening program. The state MCH is for the current year allocation as the state match for the carryover was expended during the current fiscal year. The total FY 06 MCH budget is $3,608,709. As required, the FY 06 MCH budget complies with the FY 89 Maintenance of Effort amount. This amount represents $853,034.

For FY 06, 30.0% of the federal Title V allocation is directed to Section 1 of Form 2,Component A, Preventive and primary care for children and adolescents that amounts to $592,922. Direct services provided under Component A are primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. Services are provided through community based non-profit agencies, as well as through the health districts in Clark County and Washoe County. In addition to direct services, Component A includes funding for the continued development of core public health/infrastructure activities including oral health and teen pregnancy prevention to ensure appropriate and continued services to children and adolescents.

For FY 06, 30.0% of the federal Title V allotment is directed towards Children with Special Health Care Needs, Section 1, Form 2, Component B. The allotment budgeted for Component B services amounts to $592,922. The individuals to be served under Component B are children with special health care needs and their families. Services funded under this component are primarily enabling services and are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through several mechanisms: through the Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists and physical therapists who are under contract to the CSHCN program and the CSHCN treatment program. In FY 05 all these services are provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City. They will also support the pilot projects for CSHCN systems of care in Nevada that will be developed by the Real Choice Systems Change grant project.

For FY 06, Administrative costs, Section 1, Form 2, Component C will not exceed $197,640, which is 10% of the current period grant request total. For FY 06, the remaining federal Title V allotment is directed towards services for pregnant women and postpartum women and infants up to age 1 year. The allotment budgeted for services is $592,921. The individuals to be served are pregnant and postpartum women and infants up to age 1 year statewide. Services are designed to be family-

centered, community based, culturally appropriate and comprehensive. Direct services are provided through contracts with local agencies, including health districts and community based non-profit agencies. In addition, funding includes the continued development of core public health/infrastructure activities. The integration of perinatal substance abuse services including prevention of fetal alcohol syndrome into routine perinatal services received by all pregnant women is an example of the core public health activities to be continued in FY 06. A newly proposed breastfeeding initiative of the American Academy of Pediatrics will be supported through this component. Also included is the State's Newborn Screening program, which screens almost every infant born in the state for inborn errors of metabolism and hemoglobinopathies. The mandated newborn hearing screening passed during the State's 2002 Legislature (those born at hospitals with over 500 births) will be part of the program. Follow-up for the identified children is included in Component B.

Overall, allocation of MCH dollars across Components A, B, & C is based upon unmet health care needs identified in the Year 2000 Five Year MCH Needs Assessment. The state assures a fair and equitable method of distributing funds based upon identified needs.

Nevada's MCH unexpended grant balance, as reported in last year's application, was basically expended as planned over the current 2004-2005 biennium. The goal was to leave approximately $150,000 in unexpended grant balance at the end of the upcoming biennium and this goal was met in FY 04. Nevada's Title V Maternal and Child Health Block grant has been fully budgeted through the Legislative process for the 2005-2006 biennium.

Other federal funds administered by the MCH Chief besides the Maternal and Child Health Title V Block Grant Program include a United States Department of Agriculture (USDA) grant for the state WIC program; Abstinence-Only Education, and State Systems Development Initiative grants funded by MCHB; Oral Health, Rape Prevention and Education, and Injury Prevention grants from CDC; Sexual Assault Prevention from PHHS, Real Choice Systems Change from CMS and Primary Care and NSHC SEARCH Program from the Bureau of Primary Health Care. Other federal grants include Early Childhood Comprehensive Systems, Newborn Hearing Screening and Children's Oral Health that provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with approved grant proposals.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.